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FAMILY PLANNING

An Analysis Of
Laws And Policies In
The United States



Family Planning, Contraception, and Voluntary Sterilization: An Analysis of Laws and Policies in the United States, Each State and Jurisdiction

(As of September 1971)

A Report of The National Center for Family Planning Services.

Health Services and Mental Health Administration
U.S. Department of Health, Education, and Welfare.

Prepared by the
Center for Family Planning Program Development
The Technical Assistance Division of
Planned Parenthood—World Population

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Foreword

The last decade has brought striking changes in public attitudes toward family planning and in State and Federal legislation and regulations covering family planning, contraception, and voluntary sterilization.

Recognizing the significance of these attitudinal and legislative changes, the National Center for Family Planning Services provided contract support to Planned Parenthood-World Population for a series of profiles on State Laws and a compilation of Federal legislation and regulations. The document research, completed in early 1972, covers legislation in effect as of September 1971. The increased popularity of family planning services along with increased legislative interest, however, have brought about many more recent changes. It has been necessary, therefore, to include new State enactments and an update of the Federal section of the study.

This document, which will permit the orderly and regular updating of changes in State and Federal laws, should serve as an invaluable basic reference for those who are concerned with the state of the Nation's laws on all aspects of family planning, including the rights of minors. Users and providers of family planning services now have available a definitive State-by-State compilation of the law and what its provisions mean to them.

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Deputy Assistant Secretary for
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Addenda

The following new developments in the law and regulations came to our attention too late to be included in the text of the study:

Federal Laws and Policies

Title X, Public Health Service Act

General Provisions and Special Requirements

PL91-572, the Family Planning Services and Population Research Act, which was enacted in 1970, was to expire on June 30, 1973. On June 18, 1973, the President signed into law the Health Programs Extension Act of 1973 (PL93-45) which extends for one year 12 public health programs, including family planning, in the same form in which they were last adopted. The funding levels for family planning contained in PL 93-45 correspond to the budget levels requested by the President for FY 1974—\$111,500,000 for project grants, \$3,000,000 for training, \$2,615,000 for operational research, demonstration and evaluation and \$909,000 for educational materials related to population and family planning.

A "Conscience" clause in regard to the performance of sterilization or abortion procedures, originally sponsored by Senator Frank Church (D-Idaho) is incorporated in the Health Programs Extension Act of 1973. It provides that:

The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act by any individual or entity does not authorize any court or any public official or other public authority to require—

(1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or

(2) such entity to—

(A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary

to the religious beliefs or moral convictions of such personnel.

and that

No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act after the date of enactment of this Act may—

(1) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

(2) discriminate in the extension of staff or other privileges to any physician or other health care personnel, because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortion.

Eligibility for Services

Department of Health, Education, and Welfare regulations on "Grants for Family Planning Services" published in the *Federal Register* on September 15, 1971 and subsequently revised in the *Federal Register* of March 16 and December 14, 1972 implement the provision (in sec. 1006) of the Title X legislation which requires that in the provision of family planning services, priority will be given to the "furnishing of such services to persons from low income families," and that "no charge will be made" for "services provided to any person from a low income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge." This section delegated to the Secretary of DHEW the responsibility to define "the term 'low income family' in accordance with such criteria as he may prescribe."

Under these regulations (42 CFR Part 59), "low-income" is defined broadly using income schedules and lists of exemptions proposed by the Administration in the National Health Insurance Partnership Act and the Family Assistance Plan, respectively, during the 91st and 92nd Congressional Sessions.

Participation in the federally subsidized Family Health Insurance Plan was to be limited to families with annual incomes of under \$7,000 (for a family of seven or more) or \$5,000 for a family of four. The Family Assistance Plan would have permitted such exemptions as student earnings, irregular income of small amounts, cost of child care necessary for employment that "... If charges are to be made to persons other than those from low income families, such charges must be made in accordance with a schedule submitted and approved as part of the project plan."

Administration

On July 9, 1973, DHEW published in the *Federal Register* a reorganization order affecting the basic structure of the Public Health Service. The Health Services and Mental Health Administration, a component of the Public Health Service, was abolished July 1, 1973. Some of its functions were transferred to other agencies of DHEW, the others consolidated into three separate health agencies: the Center for Disease Control, the Health Resources Administration and the Health Services Administration. The Health Services Administration, according to the reorganization order "shall be responsible for providing and financing the delivery of health services through grants, contracts, and direct delivery; for integrating service delivery programs with public and private health financing programs; for administering State formula grant-supported health service programs; and for assuring quality and containing costs of services provided through the public financing programs." "The Health Services Administration shall carry out its responsibilities through the Office of the Administrator and the following newly established bureaus and services which shall perform those functions formerly carried out by those organizational units listed thereunder:

Office of the Administrator

Indian Health Service

(All of the presently assigned functions)

Federal Health Programs Service

(All of the presently assigned functions)

Bureau of Community Health Services

National Center for Family Planning Service

Maternal and Child Health Service

Community Health Service (except for the Office of Long-Term Care Services and the Division of Medical Care Standards)

National Health Service Corps

Health Maintenance Organization Service

Bureau of Quality Assurance

Division of Medical Care Standards

Prior to July 1, 1973, the National Center for Family Planning Services was a component agency of HSMHA under the immediate supervision of its administrator. The reorganization order places

NCFPS under the Bureau of Community Health Services, which is in turn a component agency of HSA. The plan of organization of the new Bureau of Community Health Services had not been published in the *Federal Register* as of January 1, 1973.

Title V, Social Security Act

General Provisions

The 1967 amendments to the Social Security Act provided that "not less" than 6% of the funds appropriated each year for Maternal and Child Health and Crippled Children's Services (Title V, SSA) would be earmarked for family planning services. For a period of 5 years, or until June 30, 1972, the funds appropriated under Title V were to be allocated so that 40% of the funds would be reserved for all project grants, 10% for training and research and 50% would be distributed to the states on the basis of a formula established in the law. After June 30, 1972, all funds for service programs (or 90%) would be allocated on a formula basis and administered by state health agencies. 10% would remain reserved for training and research and administered federally.

On June 30, 1972, the effective date of these provisions was postponed by Congress until June 30, 1973 (PL92-354). On that date, Congress again moved up the effective date on which project grants would be transformed into formula grants. At the same time it adopted several amendments to Title V which are summarized as follows in the Report of the Senate Committee on Finance (No. 93-349)

Under present law, of the funds appropriated for the Maternal and Child Health program, 50 percent is allocated to States on a formula basis, 40 percent is available for special project grants, and 10 percent is available for training and research projects. Under present law, the project grant authorization would terminate on July 1, 1973 and those funds would be available under the State formula grants—thus making 90 percent of the total money authorized available on a formula basis.

The Committee bill includes a provision extending the authorization for project grants until June 30, 1974; after that date, 90 percent of the Maternal and Child Health funds would be allocated on the formula basis. However, the Committee amendment provides (1) an additional authorization so that no State would be eligible for less funds after June 30, 1974 than the total amount allocated to a State in formula and project grants in FY 1973, and (2) that States would be required to make appropriate arrangements for the continuation of services to the population in areas previously served under project grants. Under a special provision, in fiscal year 1974 an additional authorization would result in each State being eligible to receive the greater of (1) the total of fiscal year 1973 project and formula grants, or (2) the sum of each amounts as the State would have otherwise been entitled to if the project grants had not been extended during fiscal year 1974.

On July 1, the President signed the Title V amendments into law as part of a bill raising the public debt ceiling (PL93-53).

Administration

Effective July 1, 1973, under the Public Health Service reorganization published in the *Federal Register* on July 9, the Maternal and Child Health Service functions became part of the responsibility of the Bureau of Community Health Services, itself a component of the new Health Services Administration created by the reorganization order. (See above, *Title X PHSA*).

Title XIX, Social Security Act

The family planning provisions of Title XIX, Medicaid, were significantly strengthened by the Social Security Amendments of 1972. Section 1905 (a) (4) makes family planning services and supplies a mandatory, basic service which states must make available to all "individuals of childbearing age (including minors who can be considered to be sexually active)" who are Medicaid-eligible and "who desire such services and supplies."

Section 1903 (a) allows all states to claim 90 percent federal reimbursement for Medicaid family planning services and supplies. (Under the previous law, those states that elected to claim Medicaid reimbursement for family planning services were reimbursed at a rate inversely proportional to the per capita income of the state with federal reimbursement ranging from 50 to 83 percent.) With the amendments to section 1903 (a), states are permitted to claim 90 percent reimbursement for expenditures "which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies." Since Medicaid continues to be funded on an open-ended federal funding authority, there is no ceiling on the amount of available federal matching dollars.

Although DHEW on June 13, 1973, issued proposed Medicaid regulations to implement the family planning changes mandated by the 1972 law, no final Medicaid family planning regulations have been adopted.

Title IV-A Social Security Act

PL 92-512, the State and Local Financial Assistance Act of 1972 (Revenue Sharing), which the President signed into law on October 20, 1972 eliminates the prior open-ended federal funding authority for Title IV-A social services programs by establishing a \$2.5 billion ceiling on federal payments to the states for all social services programs. The law also requires that 90% of state social services expendi-

tures be made on behalf of current welfare recipients. There are, however five categories of services: child care, family planning services to the mentally retarded, alcoholics and drug addicts, or to children in foster care which are exempted from this general rule. Under PL 92-512, therefore, there are no restrictions on the provision of family planning services to former and potential recipients of welfare assistance if the states elect to provide services to these individuals or families.

On October 30, 1972, the President signed into law PL 92-603, the Social Security Amendments of 1972 which make several changes in the family planning provisions of Title IV-A SSA, first enacted in 1967. The law specifies that services must not only be offered but "provided promptly" on a voluntary basis, and that they must be provided specifically to "minors who can be considered sexually active." The federal matching rate is increased from 75% to 90% for all state activities "attributable to the offering, arranging and furnishing, directly or on a contract basis, of family planning services and supplies." States, beginning in FY 1974, are subject to a one percent reduction in the federal share of their AFDC funds if they fail to offer and provide family planning services to the recipients of public assistance and, to former applicants or recipients under certain conditions. (Sections 402 and 403)

Final regulations to implement the changes in state social services programs mandated by PL 92-512 and PL 92-603 were promulgated by DHEW in the *Federal Register* on October 31, 1973, effective the next day. These regulations revoke Part 220 of the Code of Federal Regulations and establish a new Part 221. Section 221.9 of the Code now defines Title IV-A family planning services as:

social, educational, and medical services to enable appropriate individuals (including minors who can be considered to be sexually active) to limit voluntarily the family size or space the children, and to prevent or reduce the incidence of births out of wedlock. Such services include printed materials, group discussions, and individual interviews which provide information about and discussion of family planning; medical contraceptive services and supplies; and help in utilizing medical and educational resources available in the community. Such services must be offered and be provided promptly (directly or under arrangements with others) to all eligible individuals voluntarily requesting them.

As in the past, states have the optional authority to extend family planning services to former applicants and recipients and to potential recipients. But former applicants and recipients are now defined by section 221.6 as those persons who applied for or received benefits "within the previous three months." However, section 221.6 contains a separate, new eligibility criteria for potential recipients which states that:

any female of childbearing age who requests family planning services may be considered eligible to receive such services . . . provided such individual has gross monthly income which, after deducting \$60, does not exceed 150 percent of the State's standard of need under Title IV-A for one adult plus one child, or, if she is part of a family unit, then the applicable need standard for such family unit plus one child.

The previous authority to determine eligibility for social services on the basis of group or geographic eligibility criteria has been eliminated, and section 221.7 provides that "The State agency must make a determination that each family and individual is eligible for social services prior to the provision of services under the state plan."

Economic Opportunity Act

The transfer of OEO programs to DHEW, initiated on April 29, 1971, became effectively complete when the President signed the executive order delegating authority over all remaining OEO health programs to the Secretary of DHEW.

Food, Drug and Cosmetics Act

On March 7, 1973, the Food and Drug Administration published a "Statement of Policy Concerning New Drug Status of Certain Intrauterine Devices" in the *Federal Register* which indicated that "Intrauterine devices used for the purpose of contraception and incorporating heavy metals, drugs, or other active substances to increase the contraceptive effect, to decrease adverse reactions, or to provide increased medical acceptability, are not generally recognized as safe and effective for contraception and are new drugs within the meaning of section 201 (p) of the Federal Food, Drug, and Cosmetic Act. A completed and signed 'Notice of Claimed Investigational Exemption for a New Drug' (Form FD 1571 set forth in § 130.3 (a) (2)) must therefore be submitted to cover clinical investigations to obtain evidence that such preparations are safe and effective for this use. An approved new drug application is required for the marketing of such articles."

On September 26, 1973, FDA issued regulations which require physicians to discuss with their patients the advantages and possible disadvantages or contraindications of the post-coital use of diethylstilbestrol (DES or the morning-after pill) and warn them as well against repeated use of the drug. In addition, a printed insert similar to that currently used for oral contraceptives will be required in each drug package.

On October 10, 1973, FDA published a notice of "Proposed Patient Labelling" for the contraceptive use of medroxyprogesterone acetate. The drug, better known as Depo-Provera, a long acting injectable,

is to be prescribed only to "certain patients" who are willing to accept the risk that it may produce temporary or even permanent infertility, and who are unable or unwilling to use other contraceptive means.

A printed insert in each drug package, as well as a more detailed brochure, explaining "... the risks involved in the use of the drug and the type of patient for whom it is intended" must be furnished to the patient, or, in the event she is not competent to understand the information, the patient's parent or guardian. The use of the drug is to be monitored through a special registry.

Miscellaneous

Sterilization

On September 21, 1973, DHEW published in the *Federal Register* two sets of proposed regulations which would set forth the policies of the Department regarding the use of federal funds for sterilization procedures. These policies would affect programs financed and administered by the Public Health Service (the Health Services Administration, the Health Resources Administration, the National Institutes of Health, the Center for Disease Control and the Food and Drug Administration, as well as all their constituent agencies and programs) and by the Social and Rehabilitation Service (as they affect the Title XIX program).

The regulations provide that federal funds may not be used to finance nontherapeutic sterilization procedures unless the individual or patient is over the age of 21 and "legally competent" and has given written "informed consent" to the sterilization. In the case of persons under 21 or legally incapable of giving informed consent (by reason of mental deficiency or incapacity), the sterilization would have to be approved by a five-person review committee established by the project (in the case of programs funded by project grants) or under the state plan (in the case of the Medicaid program). In addition to the committee approval, the regulations would require that "a court of competent jurisdiction has determined that the proposed sterilization is in the best interest of the patient." The *Federal Register* issuance also states that the regulations "are not intended to require any program or project to arrange for sterilization."

There were no federal regulations or guidelines regarding the sterilization of persons legally incapable of giving informed consent prior to the issuance in the *Federal Register* on August 3 of preliminary guidelines which established a formal moratorium on sterilization procedures for this category of persons pending the issuance of final regulations. Such regulations remain to be issued.

Migrant Health

The regulations on "Grants for Migrant Health Service," published in the *Federal Register* on December 28, 1971, define eligibility for services under the Migrant Program, the conditions under which grant applications may be made, the size and composition of individual projects' policy boards, etc. The regulations state that in order to be approved a project application must provide "... that the project will deliver or arrange for the delivery of family-oriented primary care which shall include but not be limited to ... preventive, maternal, child health and family planning services integrated into the delivery of treatment services ..." 42.CFR Part 56, "Grants for Migrant Health Services."

State Laws and Policies

Connecticut. Connecticut has a 1972 statute authorizing medical and surgical sterilization procedures. These may be performed by licensed doctors after legal consent to the procedure has been obtained. Conn. Gen. Stat. Ann § 19-66d (Cum. Supp. 1972).

Idaho. In March, 1971, Idaho amended § 39-807 of the Idaho Code, which prohibits the display or advertising of contraceptives and prophylactics. The statute had previously made an exception for advertising in medical and drug publications and in literature enclosed in or around the original package. A new exception permits national advertising by manufacturers of contraceptives and prophylactics. 1971 Idaho Session Laws, Chapter 160, H.B. No. 251.

Kentucky. Kentucky in 1972 repealed statutes which prohibited the display or advertising of prophylactics. Repealed were Ky. Rev. Stat. § 214.230 (which made it illegal to display or advertise prophylactics or their packages) and Ky. Rev. Stat. § 438.070 (which made it illegal to publish an advertisement about VD or its treatment). Kentucky also modified Ky. Rev. Stat. § 214.200, which provides for the licensing of sellers of prophylactics, by deleting a requirement that sales under a retailer's license could be made only from the prescription counter of the drug store and only by a registered pharmacist. Senate Bill No. 299, Regular Session 1972.

In a separate development, the Kentucky Court of Appeals in 1971 decided when the statute of limitations begins to run in an action for damages for an unsuccessful vasectomy. The court assumed the legality of voluntary sterilization in Kentucky. *Hackworth v. Hart*, 474 S.W. 2d 377 (Dec. 17, 1971).

Louisiana. A minor "who is or believes himself to be afflicted with an illness or disease" may consent to medical or surgical care, and no parental or spousal consent will be required. La. Rev. Stat. § 40:1065.3

added by Laws 1972 Reg. Sess. Act 182 (H.B. No. 355).

Mississippi. Mississippi has adopted the "Family Planning Act of 1972." (S.B. No. 1560, Regular Session 1972, effective July 1, 1972). This law authorizes the State Board of Health to receive and disburse such funds as may become available to it for family planning programs to any organization, public or private, engaged in providing contraceptive procedures, supplies and information. ("Contraceptive procedures" are defined as "any medically accepted procedure designed to prevent conception." "Contraceptive supplies" are defined as "those medically approved items designed to prevent conception through chemical, mechanical, or other means.")

The State Board of Health is authorized to adopt and promulgate rules and regulations to implement the provisions of the act.

The Board may "provide for the dissemination of medically acceptable contraceptive information and supplies by duly authorized persons in state and county health and welfare departments and in medical facilities at institutions of higher learning."

The new law specifically provides that "[c]ontraceptive supplies and information may be furnished by physicians to any minor who is a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such service by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of [the state of Mississippi] or any subdivision thereof."

Nebraska. In May, 1972, the Supreme Court of Nebraska reversed a lower court ruling that the custody of two young children in a divorce action should be given to their father. The lower court ruling was based on the fact that the father had had a vasectomy and would be unable to have children in the future. The Supreme Court reversed on the ground that custody must be based on the best interests and welfare of the children, which would be served by granting custody to the mother. The court assumed the legality of voluntary sterilization in Nebraska, *Gydesen v. Gydesen*, 198 N.W. 2d 67.

Pennsylvania. In May, 1972, a Pennsylvania court refused to permit the appointment of a guardian for the purpose of consenting to a blood transfusion preparatory to a spinal fusion operation on a 16-year-old boy where the parents objected to the transfusion for religious reasons and where the child's life was "not immediately imperiled by his physical condition." The court remanded the case for an evidentiary hearing to determine the boy's wishes, stating:

It would be most anomalous to ignore the child in this situation when the preference of an intelligent child of

sufficient maturity in determining custody has been considered. Moreover, it has been held that a child of the same age can waive constitutional rights and receive a life sentence. Indeed, minors can now bring a personal injury action in Pennsylvania against their parents. In *re Green*, 41 U.S. Law Week 2013 (7/11/72) (decided by Pa. Sup. Ct. 5/3/72).

Texas. In February, 1972, a Texas appellate court ruled that an action to recover damages for an unsuccessful vasectomy was barred by the statute of limitations. The court assumed the legality of voluntary sterilization in Texas.

The plaintiffs, a man and his wife, had had two children, both afflicted with spina bifida and meningocele. The man had a vasectomy, after which two more children were born to the wife. Of these two, one suffered from the same birth defects and died; the second was normal. The appellate court stated that no damages could be allowed for the birth and care of the normal child, as that would compel the physician to pay for the satisfaction and joy that normal parents have in bringing up a healthy child. *Hays v. Hall*, 477 S.W. 2d 402 (Tex. Ct. of Civ. App.).

Utah. On May 17, 1972, the Utah Supreme Court held that Utah Code Ann. § 64-10-12 (which had been thought to prohibit voluntary sterilization except for reasons of medical necessity) applies only to mental defectives, and that Utah law "places no restriction upon the right of individuals to have . . . a sterilization operation if they so desire." *Parker, et al. v. Rampton, et al.*, Supreme Court of Utah No. 12494. This decision means that voluntary sterilization for all reasons is now legal in all states.

Virginia. Virginia has a law, which became effective July 1, 1972, providing that every applicant for a marriage license shall be given birth control information and a list of family planning clinics to be furnished by the State Department of Health. Va. Code Ann. § 20-14.2 (added by House Bill 1095, 1972).

Another Virginia law, which also became effective

July 1, 1972, greatly simplifies the statutory requirements for voluntary sterilization. While the old law authorized only vasectomy or salpingectomy, the new law also authorizes any other surgical sterilization procedure. The new law removes the former requirement that the procedure be performed in a licensed hospital and the former requirement that the physician or surgeon performing the operation consult or collaborate with at least one other licensed physician or surgeon. House Bill 291, 1972.

The new sterilization law also modifies the former provision that no sterilization operation could be performed until 30 days from the date of consent or request therefore by eliminating that requirement for any female who has given birth to a child. In addition, the new law dispenses with the requirement of spousal consent where the person requesting the operation states in writing under oath that his or her spouse has disappeared or that they have been separated continually for a period of more than *one year* prior thereto (the old law had specified a two year period). *Ibid.*

West Virginia. West Virginia has a new law, which became effective in June, 1972, permitting local boards of health to disseminate information about voluntary sterilization procedures in their family planning program. House Bill No. 792, 1972 (amending W. Va. Code Ann. § 16-2B-2, which formerly excluded sterilization from the program.)

District of Columbia. On June 5, 1972, U.S. District Court Judge Aubrey E. Robinson, Jr. ordered the District of Columbia General Hospital (a public hospital) to stop requiring the consent of the husband when a married woman applies for an abortion or sterilization. The court ruled that the hospital's policy of requiring such consent "deprives poor married women . . . of their right to receive medical care [and] to control their own bodies . . ." *Jane Coe et al. v. District of Columbia General Hospital et al.*, U.S. District Court for the District of Columbia, Civil Action No. 1477-71.

General Introductory Note¹

This study has been prepared pursuant to Contract No. HSM 110-71-271 between the Center for Family Planning Program Development (CFPPD), the Technical Assistance Division of Planned Parenthood-World Population (PPWP), and the National Center for Family Planning Services (NCFPS), Health Services and Mental Health Administration (HSMHA), U.S. Department of Health, Education and Welfare (DHEW).

The Project Director for the study is Attorney Harriet F. Pilpel. The Director of CFPPD is Frederick S. Jaffe. The legal research and analysis of restrictive federal laws and of all relevant state laws has been done by Attorneys Eve Paul, Peter Ames, Paula Ryan and Lanny Oppenheim under the supervision of Mrs. Pilpel and Mrs. Nancy Wechsler, who are partners in the law firm of Greenbaum, Wolff & Ernst.

Federal affirmative laws and federal agency regulations and state health and welfare department policies have been assembled and analyzed by the Public Policy Unit staff of the CFPPD under the direction of Mrs. Jeannie I. Rosoff, CFPPD Associate Director. Staff members who worked on this part of the project are Donald Fisher, Jan Liebman, Barry Nestor and David Weinberg.

The study is designed to assemble and analyze existing federal, state and territorial law, policies and regulations regarding contraception and voluntary sterilization and the conditions under which minors may receive these services. In addition to the federal government and the 50 states, this study covers the District of Columbia, American Samoa, Guam, Puerto Rico and the U.S. Virgin Islands. The study includes a brief discussion of artificial insemination, based on previously available data, identifying the legal issues and referring to other sources of information.

Terminology

The terms "family planning," "contraception" and "birth control" are used as synonyms herein. For reasons of presentation those terms as used in this study ordinarily do not include voluntary sterilization unless specifically indicated, although voluntary sterilization is regarded as one method of birth control.

The law and policy in the subject areas covered in this study are changing so rapidly that it is not unlikely that additional developments will have oc-

curred by the time the study appears. While this may affect the law and policy in individual states or territories, we do not believe it is likely to affect the general discussion of the emerging trends.

The study speaks as of September 1, 1971 although in a few instances later developments are included.

Subjects Not Covered

The following subjects are *not* covered by this study unless they are an aspect of laws, court decisions or Attorneys General's opinions primarily dealing with family planning or voluntary sterilization:

1. Sex and family planning education.
2. State pharmaceutical regulations and laws dealing in general terms with the distribution of drugs and devices.
3. Licensing of clinics, pharmacies or other medical-related facilities in general.
4. Laws and regulations governing hospitals and hospital policies.
5. Medical specialties and ethics.
6. Use of paraprofessional personnel.
7. General obscenity and pornography laws (except, of course, those relating, or which have been interpreted to relate, specifically to contraception or voluntary sterilization.)
8. Compulsory sterilization.
9. Mental health and laws concerning insane and incompetent persons.
10. Laws regulating prisons and prison policies.
11. Malpractice.
12. Venereal disease statutes (except as they relate to sale, distribution, advertising and display of prophylactics, and consent of minors to treatment for venereal disease).

With regard to malpractice, the law in the fields of contraception and voluntary sterilization is the same as in other fields of medicine, i.e., there must be informed consent by a person with the legal capacity to consent and the procedure must not be negligently done.

Inquiries with regard to paraprofessionals should be directed to State Departments of Health.

Footnote to General Introductory Note

1. The study does not include local ordinances or regulations and policies adopted by governmental bodies below the state level except in occasional instances where they are cited to clarify state law.

Methodology

1. Federal Laws and Policies

The study of federal laws and policies is based on those documents which were codified and independently verifiable. This analysis deals primarily with the laws, policies and practices governing the provision of services associated with contraception and voluntary sterilization. In accordance with an agreement with the National Center for Family Planning Services (NCFPS), the data sources to be used for the federal material were the *Federal Register*, published manuals, documents, policy statements and guidelines in the public domain.

*The 1971 Catalog of Federal Domestic Assistance*¹ was used to identify all programs which might be relevant to contraception and family planning. All the laws which establish and govern these programs were collected and reviewed. These included laws administered by the Department of Health, Education, and Welfare (DHEW), the Department of Labor (DOL), the Office of Economic Opportunity (OEO), the U.S. Postal Service (USPS), the Department of Defense (DOD) and the Department of Housing and Urban Development (HUD). Each law which specifically mentions family planning or contraception was identified and analyzed. All regulations specifically related to implementation of family planning laws were identified from the *Code of Federal Regulations* and the editions of the *Federal Register* issued since the last codification, and were appropriately analyzed. The *Code of Federal Regulations* and the *Federal Register* were used to determine which of the general health programs of the federal government (e.g., Medicaid, Comprehensive Health Services and Planning, Appalachian Regional Development, Migrant Health, Indian Health, Federal Employee's health services) refer specifically to the provision of family planning services in their official regulations.

Other documents used when available were: official guidelines detailing implementation of the family planning program regulations; state plan guide manuals; agency annual reports to Congress; official studies of the federal government; the Budget of the United States; Presidential messages; Congressional hearings and reports, and the *Congressional Record*.

There may be omissions of relevant material not codified or published in the *Federal Register* or

otherwise generally available. Such omissions could only have been corrected through consultation with the agencies involved, which, as noted above, was precluded by the conditions of the study.

The *federal laws* which have *specific* provisions relating to family planning or contraception are:

- Public Health Service Act, Title X
- Social Security Act, Title IV-A, Title V
- Economic Opportunity Act, Title II
- Emergency Employment Act
- The Postal Law

In addition, the *Code of Federal Regulations* has some *specific* reference to family planning in the sections which govern the implementation of Title XIX of the Social Security Act, the Medicaid program. There are also references in the *Federal Register* to contraceptive articles and devices which are regulated under the Food, Drug and Cosmetic Act, and to "... family planning services and supplies ..." within the Department of the Army of the Department of Defense. All of the above are encompassed by this study.

Other materials of a less formal and official nature were on hand, among them 'state letters,' program instruction memoranda, circulars, reports, letters and speeches. These documents are incomplete and, perhaps, obsolete. They were excluded from the study, since they could not be verified for accuracy, currency and completeness. However, two exceptions were made to this exclusion:

- First, an exception was made of noncodified, non-verified materials from the OEO. The Economic Opportunity Act specifically authorizes a family planning services program; funds are specifically earmarked for its support under the authorizing legislation, and the FY 1972 United States Budget projects a \$24 million expenditure for OEO family planning services. However, there are no specific federal regulations governing the program. All OEO health programs, including family planning, are administered on the basis either of internal publications or external publications having limited distribution. In view of the importance of the OEO program, and in the absence of codified or other formal regulations and information, we drew on the guidelines in *Community Action for Health: Family*

Planning, OEO, October 1967 and other materials available to us. This material has not been verified although, to the best of our knowledge, it is accurate and current.

- The second exception concerns the provision of family planning services to retired members and dependents of members of the uniformed services (Army, Navy, Air Corps, Public Health Service, Coast Guard and Commissioned Corps of The National Oceanic and Atmospheric Administration) under the general authority of the Military Medical Benefits Amendments of 1966. Although there is no mention of family planning services in the law, the Department of the Army's regulations govern the provision of all family planning services. The Departments of the Navy, the Air Force and the Public Health Service have also issued program directives which govern their provision of family planning services. Since these materials are readily available at all military or public health installations, it was felt that their accuracy could be accepted without further verification. For these reasons they are included in the study.

A number of federal agencies which have responsibility for the provision of general health care to subgroups of the population (Indians, migrants, federal employees and their dependents, etc.) have a concern for the provision of family planning services which is reflected in their annual reports, Congressional budget presentations or other documents. However, these documents do not constitute explicit and formal statements of actual policies comparable to issuance of federal regulations.² Some of these agencies are reported to be preparing or revising policies and program instructions in regard to family planning. However, the conditions of the study precluded their inclusion.

2. State Laws

The legal portion of this study is based upon research into statutory and decisional law performed in the law libraries of the Association of the Bar of the City of New York, Columbia University Law School and New York University Law School.

The law libraries used for the research done in this study have complete collections of state statutes and cases, generally updated through 1970 at the time the research was completed. To the extent that each library's resources are kept updated on varying schedules, the use of three libraries rather than one provided an opportunity to obtain materials as current as possible. However, some states do not update their annotated statute books annually, and often there is a lag of six months or even a year in receipt of current supplements in law libraries.

Moreover, the libraries do not have complete or entirely up-to-date collections of Attorneys General's

opinions. In addition, these law libraries do not have case law for the four territories covered by this study, and the territorial statutes are in general poorly indexed.

In order to close these gaps, and, in addition, to obtain materials that might not be officially published or indexed, letters were sent in August 1971 to the Attorneys General of the 50 states and, later, the District of Columbia, American Samoa, Guam, Puerto Rico and the Virgin Islands. These letters, accompanied by statutory material we had found as of the date the letters were sent out, requested the Attorneys General to review the material for completeness and accuracy and to send us any additional legislation, cases or Attorneys General's opinions on the following subjects of relevance to the study:

- Contraception (including sale, distribution, advertising and display of contraceptive drugs and appliances)
- Voluntary sterilization
- Family planning services
- Availability to minors of contraceptive drugs and appliances and family planning services, including
 - a) laws specifically relating to the provision of such services to minors;
 - b) laws relating to treatment of minors for venereal disease or pregnancy;
 - c) laws which in general terms cover medical services to minors; and
 - d) laws enabling minors to enter into contracts at the age of 18 or lowering the age of majority.

The Attorneys General were for the most part extremely cooperative and helpful. Data were received from all of the Attorneys General except those of the states of Indiana, Maryland, New York, Oklahoma, Rhode Island, West Virginia and Wisconsin. Follow-up telephone calls helped us update these responses. Because of the inadequacies of the law libraries as to laws in the four territories covered in this study, analysis of the law for Guam, Puerto Rico, the Virgin Islands and American Samoa is based upon the responses received from each Attorney General as to the law of his territory. Where Attorneys General's opinions are cited, it should be recalled that these do not have the legal effect of a statute or court decision but represent the Attorney General's informed opinion as to the law of his state at a given time. In most states, executive and administrative agencies are normally guided by an Attorney General's opinion as to that state's law in the absence of a governing judicial decision.

In addition to library research and contact with the state Attorneys General, use was also made of the legal files of Greenbaum, Wolff & Ernst, a New York based law firm with extensive experience in the fields covered by this study.

In our library research, both primary and secondary source materials were used. Primary material consisted of state and federal statutes and reported cases. In general, statutes were found by searching the indexes to the official state codes and their supplements, and the available volumes of the most recent Session Laws. Topics which were searched when applicable included such subjects as Assault and Battery, Bastardy, Birth Control, Children, Consent, Conception, Contraception, Contracts, Constitutional Law, Counties, Divorce, Drugs, Family Planning, Husband & Wife, Infants, Mayhem, Mental Health, Minors, Parent and Child, Pharmacies, Physicians & Surgeons, Population Control, Sterilization, Venereal Disease, and others.

Cases were found for the most part through annotations to various statutory sections; the state digest systems, searched under the key number for various relevant subjects; such general digests as *Corpus Juris*, *Corpus Juris Secundum*, *American Law Reports*, *American Jurisprudence*; articles and case notes in law reviews and other periodicals; citations in other cases; and various other serendipital sources. Cases were generally shepardized to insure that they were still applicable law and to ascertain whether new cases citing them had appeared in the same or other jurisdictions.

In our search for secondary sources, we used: the *Index to Legal Periodicals* to find articles in law journals and other periodicals; various services such as the *Food Drug Cosmetic Law Reporter*; selected Congressional committee reports; Attorney General reports; books and newspapers, as relevant.

The aforementioned is not intended as an exhaustive account of our research, but is meant to give the reader some idea of its scope.

The part of the study dealing with minors covers specific data applicable to the rendering of contraceptive services to minors and the voluntary sterilization of minors. It does not cover the general law governing the doctor-patient relationship. Where it is stated that a minor may effectively consent to medical treatment, the usual rules governing consent other than with reference to minority apply, including the requirement that the consenting party must have been given adequate information concerning the nature and possible consequences of the proposed treatment and the fact that consent does not relieve a physician of responsibility for negligence.

The discussion of contraceptive services to minors therefore does not include discussion of rules relating to consent for medical treatment of minors respecting blood donations, narcotic addiction, commitment to mental institutions, anatomical gifts, and the like.

To the best of our knowledge, the study is correct as of September 1, 1971. Where dates are given in parentheses following statutes, the date is that of

the most recent codification in which the statute appears. Wherever possible, official citations are given first. The form of citation used is in general that contained in *A Uniform System of Citation*, published by the Harvard Law Review Association (11th ed. 1967).

3. State Policies on Family Planning and Sterilization

The information presented on state health and welfare policies is derived from written, official documents promulgated by the states by September 1, 1971. As the term is used in this study, state policy is considered to be the composite of all health and welfare regulations, guidelines, standards, state plan issuances, and other similar documents which govern or influence the discussion and provision of family planning and sterilization services. Since policy documents in a number of states identify and assign specific administrative responsibilities for these services to particular state agencies, the structure, staff and fiscal resources of these agencies are considered to be an integral part of the overall state policy. The written policies, which are represented in the form of official documents, have been supplemented by data on eligibility, administration, and financing from other sources.

Information for the study of state policies was gathered in three phases:

- the collection of official, written policy documents of state health and welfare agencies on family planning and sterilization;
- the verification and, where necessary, the updating of these documents by the state agencies themselves;
- supplementation of information provided in the official policies with additional information from the states on eligibility standards, administration and financing.

Collection of Existing Written Policy

In early 1971 the Regional Program Officers of NCFPS, HSMHA, DHEW, surveyed state health agencies primarily to ascertain state policies on eligibility and patient fees for family planning services (See C, Table 1). A large number of official policy documents were gathered in the process and these constitute the major sources of such documents for the present study of health agency policy. The documents, which vary widely in formality and completeness, were accompanied by responses of state agency officials to several questions on eligibility and fees for family planning services asked by the NCFPS staff. Since these responses were in most cases letters signed by state health agency officials, they provided an additional source of information on health agency policies, constituting less formal interpretations

of official, written policies. These comments provided considerable insight into the process of policy development at the state level.

In early 1970 the City University of New York (CUNY), under a DHEW contract, conducted a national survey of welfare departments on the issues involved in the implementation of the family planning requirements embodied in the 1967 Amendments to the Social Security Act, Title IV-A (See B, Table 1). This study produced useful data on the problems involved in implementing the family planning requirements of Title IV-A and also provided a limited view of the family planning policies of the states. Again, a number of official policy documents were gathered and these constitute the major source of documents used for this study of state welfare agency policies in family planning.

Neither the 1971 NCFPS survey or the 1970 CUNY survey was designed specifically to elicit comprehensive data on state policies in the areas of family planning and sterilization. Although some data on sterilization policies was secured through the NCFPS survey, neither survey covered sterilization services specifically. They also left a number of areas, particularly the administration and financing of family planning and sterilization services, open to further exploration.

The major sources of supplementary information are a 1970 PPWP survey of Planned Parenthood affiliates and DHEW and OEO family planning project grantees (See A, Table 1) and a 1971 state-by-state survey of health and welfare agencies conducted by the Center for Family Planning Program Development (CFPPD) (See D, Table 1).

Table 1. Characteristics of Surveys and Inquiries Used in this Study

Survey/Inquiry	No. Sent or Directed to	Returns, Answers	No Returns, No Answers
A. PPWP Survey of DHEW and OEO Family Planning Project Grantees and Planned Parenthood Affiliates (1970)			
A. DHEW Grantees	114*	98	16
B. OEO Grantees	395	240	155
C. Planned Parenthood Affiliates	189	187	2
B. CUNY Survey on Implementation of Family Planning Provisions of the 1967 Social Security Act title IV Amendments (1970)	50 States and D.C.		
A. State Welfare Agencies	51	50	1
B. Selected Local Welfare Agencies	266 (mainly county) welfare jurisdictions	237	29
C. NCFPS-DHEW Letter of Inquiry to State Health Departments Regarding Eligibility and Patient Fee Policies (1971)	50 States and District of Columbia, Puerto Rico, Virgin Islands		
	53	44	9
D. CFPPD Survey of State Health and Welfare Policies on Family Planning (1971)	50 States, District of Columbia, Puerto Rico, Guam, Samoa, Virgin Islands		
A. State or Other U.S. Jurisdictions Health Agencies	55	53	2
B. State or Other U.S. Jurisdictions Welfare Agencies	(Same) 55	54	1

* There were 131 DHEW family planning project grants awarded in FY 1970; 17 were made to Planned Parenthood affiliates; these 17 received the questionnaire for affiliates and were eliminated from the group receiving the DHEW questionnaire; thus, 114 questionnaires were sent to DHEW grantees.

- The 1970 PPWP survey of Planned Parenthood affiliates and DHEW and OEO project grantees was designed to elicit information on federal, state and local funds being used for family planning services and on state legislation allowing physicians to provide family planning services to minors without parental consent in certain circumstances.

The questionnaire asked for information about federal grants, as well as whether the agency received any state or local funds for family planning services, whether the state legislature had adopted legislation authorizing family planning services, whether funds had been appropriated specifically for family planning services by the legislature and whether state agencies had specifically requested funds for family planning from the legislature. The respondents were also asked whether state legislation had been introduced or was pending which would allow private physicians to provide family planning services to minors without parental consent under certain circumstances and, if so, under what circumstances. The questionnaire for the nonpublic agencies contained several queries directed at Medicaid reimbursement for services.

- The 1971 CFPPD survey of state health and welfare agencies was composed of two five-page questionnaires—one for health and one for welfare agencies—sent to health and welfare directors of the 50 states, the District of Columbia, Guam, Puerto Rico, Samoa, and the Virgin Islands.

State health directors were asked to specify whether the state health agency established or recommended eligibility requirements or patient fees for family planning services. Eligibility requirements were broken down into financial, social and geographical criteria; special attention was directed to such eligibility criteria for minors as marital status, previous parenthood or pregnancy status, and whether the consent of parent or guardian was required. The questionnaire also asked which organizational unit, if any, had specific administrative responsibility for family planning services, what staff, if any, were assigned to family planning activities, and what percentage of their time they spent on family planning. Health directors were asked to identify specific program functions carried out by these program units.

With respect to financing of family planning services, health directors were asked to estimate what portion of their Maternal and Child Health (MCH) formula grant funds had been obligated for or spent on family planning services in FY 1971, to identify any state legislative appropriations made to their agencies specifically for family planning, and to specify any additional state health department funds that were spent for family planning services.

Finally, health directors were asked whether their

agencies had written policies regarding sterilization and whether these policies encompassed referrals or purchase or provision of services.

State welfare directors were asked to indicate whether state welfare agency policy required, recommended, or authorized local welfare agencies to refer eligible public assistance recipients who desired family planning services to medical family planning services sources, or whether state policy left the question of such referral to the local welfare agencies. The welfare directors were also asked to indicate whether local agencies were required to purchase or otherwise provide medical family planning services for these recipients or whether state policy recommended or authorized the purchase of such services. As in the case of health policies, the questionnaire asked which individuals were eligible for what services and whether eligibility is determined by such social conditions as age, marital status or parenthood. Welfare directors were asked if state or local welfare agencies had entered into purchase of service contracts or other formal arrangements with providers of family planning services and if there was a single, standard, statewide reimbursement rate for medical family planning services. As with health agencies, the questionnaire asked which organizational unit within the state welfare agency had specific administrative responsibility for family planning services, what staff were assigned and what functions the responsible agency performed, and, finally, what state funds, if any, were allocated to family planning services.

Verification and/or Updating of Available State Policies

The policy documents collected during the 1970 CUNY and 1971 NCFPS surveys were gathered over a period of approximately one year beginning almost two years before the cut-off date for this study, September 1, 1971. In the course of the current study, the state health and welfare agencies were asked to verify whether these documents had been superseded or whether states previously without family planning policies had since adopted them. This resulted in the updating of current policies adequate for the requirements of this study. Verified information is available for every state health department except Mississippi and Puerto Rico, the District of Columbia, American Samoa and the Virgin Islands. Verified information on state welfare policies is available for all the jurisdictions encompassed in this study except American Samoa.

Method Used to Assess Administrative Influence of State Health and Welfare Agencies

The CFPPD survey sought to discover the degree of administrative influence which state health and wel-

fare agencies may exert over the family planning policies of local health and welfare agencies.

State health directors were asked if eligibility requirements (financial, social and geographic criteria) as well as fees or payments charged for services were established by the state health agency itself, whether the state agency only recommended eligibility standards for local agencies, or whether the state agency left the eligibility policy question to the option of individual local health agencies. It is reasonable to assume that those health agencies which establish statewide eligibility standards tend to exercise a greater degree of administrative influence over local health agencies than those which only recommend policy standards or leave the question to local option.

The 1967 Amendments to Title IV-A of the Social Security Act require state welfare departments to *offer* and *provide* family planning services to welfare recipients who desire these services. Therefore, the extent of administrative initiative and control of state welfare departments can be evaluated by considering the policies they adopt in relation to referral and purchase of services. Those states with policies which require local welfare agencies both to refer clients to medical services and to purchase medical family planning services for them have policies which are not only explicitly consistent with the requirements of the Title IV-A legislation, but are also more likely to have a greater degree of administrative influence over local welfare agencies than those states which only authorize or even recommend referral and purchase.

Relationship Between Policy and Practice

It was beyond the scope of the project to evaluate the extent to which the official policy of any state corresponds to the actual practices of its agencies and its jurisdictions. Some considerable variation in implementation may be expected, since major cities often have nearly autonomous health and welfare departments and since local jurisdictions vary greatly in their political allegiances, economic, religious and ethnic make-up and the extent of their professional and fiscal resources. Even when the health or welfare program is entirely state-administered, state officials will be cognizant of these differences and take them into account in implementing the program. The extent of implementation of agency policies can be evaluated only when official policy objectives can be related to numbers of patients served, funds allocated to services, or staff assigned to family planning.

Variance between formal state policy and current agency practices was revealed in informal communications gathered during this and other studies. Particularly in the area of eligibility of minors for family planning services (which appears to be the fastest changing area of state policy on family planning), it was apparent that despite the existence of apparently restrictive laws and official policies in some states, many state health agencies, for example, recognize, if not tacitly sanction, more liberal practices at the program level. This tacit sanctioning was sometimes couched as expressions of respect for the doctor-patient relationship or for the prerogative of the individual physician to decide what medical care to render; other times it was evidenced in the state health agency's tendency to leave eligibility policy to local jurisdictions. In some instances, it is clear that this 'loosening' of state policy on eligibility is associated with an anticipation of statutory revisions, of new case holdings, or of new official policies.

Such expressions of departure from official, written policy are included in the state profiles only where they constitute interpretation of policy which can be substantiated by statements of responsible officials. In such cases, the sources are cited in the profile.

Process Used to Account for Conflicts in Written State Policies

In most states, the family planning and voluntary sterilization policies of health and welfare departments are expressed through several documents. In several states, these expressions of policy appear inconsistent with each other. The individual state health and welfare policy profiles take note of these apparent conflicts and discrepancies. The information available through the CUNY and CFPPD studies (and other independent reference sources) is used to elucidate these conflicts. However, when the written, official policy conflicts with responses provided to the CUNY and CFPPD surveys, the written policy is assumed to represent the official agency position.

Footnotes to Methodology

1. Executive Office of the President, Office of Management and Budget, October 1971.
2. Some time after the official deadline for the collection of material for this study, the Migrant Health Service issued new regulations which do mention family planning specifically.

Section I

Summary and Analysis of Federal Laws and Policies Relating to Family Planning, Contraception and Voluntary Sterilization

Federal Statutes Relating to Family Planning

There are five federal statutes which deal specifically with the provision of family planning services; these are:

- Title X of the Public Health Service Act;
- Title IV-A of the Social Security Act;
- Title V of the Social Security Act;
- Title II of the Economic Opportunity Act, and the Emergency Employment Act of 1971.

Another statute regulates the unsolicited advertising and distribution of contraceptive materials through the U.S. mails. In addition, there are several instances where there is no mention of family planning or contraception in the specific law, but it is dealt with in the official regulations (as printed in the *Federal Register*) which govern the implementation of the law. This is the case in relation to Title XIX (Medicaid) of the Social Security Act, the Military Medical Benefits Amendments of 1966, and the Food, Drug and Cosmetics Act, as amended.

The federal statutes relevant to the provision of family planning services and contraception are administered by: three federal departments—Defense (DOD), Labor (DOL), and Health, Education and Welfare (DHEW); one independent agency attached to the Office of the President—the Office of Economic Opportunity (OEO), and by one independent corporation—the United States Postal Service (USPS). Within DHEW the Health Service and Mental Health Administration (HSMHA), the Social and Rehabilitation Services (SRS) and the Food and Drug Administration (FDA), and several of their subagencies all have major program responsibilities. The detailed organizational and administrative arrangements will be discussed later in this analysis.

The federal government also supports the provision of family planning services abroad under Title X of the Foreign Assistance Act administered by the Agency for International Development (AID) of the Department of State. It also supports various population research activities, the most significant of which are authorized under Titles IV and X of

the Public Health Service Act and are administered by the Center for Population Research (CPR) of the National Institute of Child Health and Human Development (NICHD), one of the 10 institutes of the National Institutes of Health (NIH) of DHEW. These activities are beyond the scope of this study.

Domestic family planning activities are also conducted as part of the general health care provided and/or supported by the federal government to such subgroups of the population as migrants, Indians and federal employees. However, these activities are not governed by formal statements of policy comparable to issuance of federal regulations. These also are outside the scope of this study, which is limited to the more formal aspects of federal policies, i.e., those which can be traced through law, official regulations and verified material (See Section on Methodology, above).

Family Planning Provisions

All of the specific provisions in regard to the offering of family planning services contained in the federal law have been adopted or amended since 1967. This is not to say that, prior to that time, the federal government had no concern for, or involvement in, the provision of family planning services. As long ago as 1942, a policy statement of the U.S. Surgeon General¹ indicated that should the states wish to include family planning services as part of their Maternal and Child Health (MCH) programs, they could pay for them with the federal funds they received under their MCH allotment. Similarly, some of the Maternity and Infant Care (MIC) programs authorized by the 1963 Social Security Amendments gradually incorporated family planning services in their definitions of 'comprehensive' maternity care. However, a probably generous estimate indicated that, in 1967, perhaps \$5.5 million was spent through both of these channels.²

The first federal grant to support a specific family planning service project (\$8,000 to Corpus Christi, Texas) was made early in 1965 under the Economic Opportunity Act, although the Act, as adopted in 1964, did not specifically mention family planning as an antipoverty measure. By 1967, however, OEO's

budget for family planning services had risen to about \$4.5 million.

Prior to 1967, the only federal statutes specifically concerned with contraception were restrictive ones. They prohibited the importation and dissemination of contraceptive articles and of information about them through the United States mails as obscene matter. These statutes, named the 'Comstock Laws', after their chief proponent Anthony Comstock, were enacted in 1873. Over the years these laws were interpreted by the courts and the postal and other administrative authorities so as to offer little practical impediment to the dissemination of contraceptives or information about them. These restrictive laws were finally amended in 1971 to delete all references to contraception except for unsolicited contraceptives and contraceptive advertising. (For the remaining restrictions, see Federal Laws and Policies Profile on the Comstock Laws.)

The regulation of contraceptive articles and drugs is a responsibility of the Food and Drug Administration (FDA) under the Food, Drug and Cosmetics Act. All new drugs must be approved as safe and effective by the FDA before they can be placed on the market. The FDA currently does not regulate "devices" in the same manner but has proposed classifying IUDs which utilize heavy metals, drugs or other added substances (other than inert ones) as new drugs. Such IUDs would then be subject to the same rigorous testing and approval procedures as drugs such as pills or vaccines. The FDA also establishes standards of quality (strength and purity) for drugs and devices and, under this authority, establishes minimum standards for the production of condoms. Finally, the FDA regulates the labeling of drugs and devices to ensure that it neither be false nor misleading nor omit adequate warnings of potential health hazards. The FDA published regulations in June 1970 requiring that all packages of oral contraceptives contain a warning of the potential adverse effects of these drugs. (See Federal Laws and Policies Profile on the Food, Drug and Cosmetics Act).

The Emergency Employment Act of 1971 includes "family planning" as part of its definition of health care, thereby defining what health services may be provided to individuals employed under that program as well as delineating a legitimate area of employment under the Act. Supportive services including family planning are to be provided under the Act "... only where absolutely necessary to enable unemployed persons to obtain appropriate jobs."³ (See Federal Laws and Policies Profile on the Emergency Employment Act.) All other federal legislation reviewed in this study relates directly to the provision of family planning services. The actual provisions of the laws and regulations vary greatly in their scope and complexity.

For example, the regulations for the Medicaid

program established in 1965 under Title XIX of the Social Security Act only mention "family planning services"^{3a} among the various kinds of medical care authorized under the program. The regulations for the Uniformed Services Health Benefits Program under the Military Medical Benefits Amendments of 1966 mention "family planning services and supplies including counseling and guidance," and detail the procedures under which dependents may obtain sterilizations or abortions.^{3b} In both instances, family planning is only one of many categories of services, and is incidental to the broad scope of the program.

At the other end of the spectrum, the Family Planning Services and Population Research Act of 1970 (Title X of the Public Health Service Act) is entirely concerned with family planning and population, and provides for family planning grants and contracts to local service programs, and the states, as well as family planning funds for training, educational materials, and operational research, and for biomedical and social research and educational materials related to population. The law also mandates certain administrative arrangements, and requires specific and detailed arrangements for planning, reporting and evaluating the authorized programs.

In the middle range of specificity are the legislative enactments of 1967—the amendments to the OEO legislation and to Titles V and IV-A of the Social Security Act. These 1967 amendments established the principle that specified funds should be reserved for family planning services, and that specialized family planning projects should be supported. The amendments to Title V mandated that not less than six percent of all funds appropriated yearly for MCH and Crippled Children's Programs be allocated to family planning services. Other amendments authorized the support of specific project grants for family planning services as contrasted to the provision of family planning services as an incidental (and optional) element of a comprehensive maternal and child health project. Although OEO had been funding family planning projects since 1965, the 1967 amendments designated family planning as a Special Emphasis program, thereby allocating specified funds and administrative priority to family planning.

Population to be Served

Each program aims at serving a different group in the population:

- The Uniformed Services Health Benefits program includes family planning as one of the many medical services to be made available at little or no cost to the active or retired members of the Services and their dependents.

- Medicaid authorizes the reimbursement of family planning services provided to eligible persons (mainly welfare recipients).
- The MCH program is aimed at “reducing infant mortality and otherwise promoting the health of mothers and children,” particularly in “rural areas and in areas suffering from severe economic distress.”⁴
- The MIC program is intended to “reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality”;⁵ funded programs are located in areas with excess infant mortality, usually urban areas and inner city neighborhoods.
- Title IV–A of the Social Security Act requires welfare departments to offer and provide family planning services to all “appropriate” persons receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program.
- The OEO program is directed at “low income individuals of all ages, in rural and urban areas.”⁶
- Whereas all of these programs seek to serve the needs of special groups—e.g., members of the Uniformed Services and their dependents, welfare recipients, low income individuals and women for whom pregnancy is likely to be problematic due to their economic status and/or areas of residence—Title X of the Public Health Service Act aims to meet the needs of “all persons desiring such services” (although priority is placed on serving families of “low income”).⁷

Purpose of the Programs

The stated purposes of the programs also vary.

- The Uniformed Services and Medicaid programs seek to make a range of medical services available to the individuals for whom the programs have responsibility for providing health care.
- The Title IV–A and the OEO programs emphasize enabling the poor to become self-sufficient. The preamble to Title II of the OEO legislation states that the goal is to enable low income persons to “attain the skills, knowledge and motivations and to secure the opportunities needed for them to become self-sufficient.”⁸ One purpose of Title IV–A is to help individuals “attain or retain capability for self-support and care”; in addition, the Title IV–A program aims to “strengthen family life and foster child development,” and to assist in “preventing or reducing the incidence of births out of wedlock.”⁹
- The aim of the MCH and MIC programs is to improve the outcome of pregnancy among special groups at risk.

- By contrast, the Family Planning Services and Population Research Act authorizes a program the purpose of which is to provide family planning services to all who want and need them. The Act reflects the consensus expressed in the world leaders’ statement presented to U Thant on Human Rights Day, December 10, 1966,¹⁰ which declared: “We believe that the great majority of parents desire to have the knowledge and the means to plan their families; that the opportunity to decide the number and spacing of children is a basic human right.” Later President Nixon, in his July 18, 1969 message to Congress on population set as a “national goal” the securing of this right for the U.S. poor, stating: “It is my view that no American woman should be denied access to family planning assistance because of her economic condition.”

Medical Services to be Provided

The services which are to be provided to meet the expressed purposes of the various statutes vary in specificity and scope.

For example, the provision of “family planning services”—defined as “including drugs, supplies and devices, where such services are under the supervision of a physician”¹¹ is authorized, but not required, under Title XIX; and nine states report that they do *not* provide family planning services as part of their Medicaid plans. In addition, most of the remaining states have administrative restrictions limiting coverage of drugs, supplies or devices, or restricting reimbursements to certain types of providers. The services authorized are mainly of a medical nature (although the costs of transportation are also authorized—again at the states’ option).^{11a}

The medical services which are the central component of family planning services are not defined in the same way or in the same detail in each program.

- The MCH manual only states that the scope of the program may include “family planning and counselling activities.”¹²
- The Civilian Health and Medical Program of the Uniformed Services specifies “family planning services, including counselling and guidance. This includes premarital counselling, diagnostic tests and drugs and devices obtainable only by prescription. It also includes surgical procedures to produce sterilization.”¹³
- Under the Title IV–A program, family planning services are defined as “specifically including medical contraceptive services (diagnosis, treatment, supplies and follow-up), social services and educational services.” Clients must be offered a choice of method and, to the extent possible, a choice among providers of services.¹⁴

- The OEO family planning program guidelines mention the “medical components” of family planning programs, the provision of routine physical examinations and laboratory tests “auxiliary to the provision of medical contraceptives” and drugs. In May 1971, OEO announced that grant funds could henceforth be used for sterilization procedures. However, guidelines for the conduct of surgical procedures have not yet been issued.¹⁵

- The family planning services project grants guidelines under Title V and the regulations for project grants under Title X¹⁶ are considerably more specific than those of other programs, and constitute a basic protocol for medical examination and prescription. The project grant guidelines state:

Medical services that must be provided as a minimum to each patient shall include:

- a variety of medically approved methods of contraception, including, but not limited to, oral contraceptives, intrauterine devices, and the rhythm method;
- a record of pertinent medical, reproductive, and social history;
- initial and annual breast, abdominal, and pelvic examinations, including Papanicolaou smear and determination of blood pressure;
- continued supervision by a qualified physician;
- routine laboratory tests, i.e., hematocrit, urine for sugar and albumin, and a serologic test for syphilis.¹⁷

Nonmedical Services

Services ancillary to the medical component are listed in varying degrees of detail in the different program guidelines. Either “counseling,” “educational,” or “social services” is mentioned in all but the Medicaid guidelines, and are perhaps used interchangeably to describe a broad range of activities. The OEO guidelines call specifically for the provision of referral services: Family planning projects should “provide access for all clients, directly or through referral to a broad range of available medical and other health services.”¹⁸ Referral for infertility services is particularly emphasized in this context. The guide also stresses the “importance of case finding and other outreach programs as well as the provision of transportation.”¹⁹

The Title X regulations and the guidelines for family planning project grants under Title V provide greater specificity. Educational and social services are defined to include:

- identification, contact, and recruitment of prospective patients;
- information and instruction to patients and prospective patients on the utilization of family planning services;
- assistance with clinic attendance (e.g., transportation, child care) if necessary, and
- follow-up supportive services to assist patients in securing continuing medical care.²⁰

The programs are also called upon to make:

Provision for coordination and use of referral arrangements with other providers of health care services, with local health and welfare departments, hospitals, and voluntary agencies, and health services projects supported by other Federal programs.²¹

The guidelines state specifically that the following referral services should be included in the projects:

... diagnostic and treatment services with referral as indicated for the infertile couples, treatment and/or referral and follow-up of patients with complications or other suspected or diagnosed medical problems to suitable facilities.²²

OEO, Title V (project grant) and Title X programs stress the involvement of the community and of the client population. Grant applications under the Title X program must contain a

... description of how persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of the project and will be given an opportunity to participate in the implementation and evaluation of such project.²³

The DHEW Title V guidelines indicate that members of the “population to be served should be employed whenever possible. This is a means of personalizing service and improving communications.”²⁴ The guidelines also require the training of project personnel and recommend:

Each project must provide for a systematic plan for the training and career development of personnel at all levels. Special emphasis should be given to the initial and in-service training of ancillary personnel with the objective of providing job development...

Eligibility for Service

Eligibility criteria are established in the law and/or the regulations for each federal program. These criteria fall into two major categories: financial and social. The financial eligibility requirements for the various programs are specified in Table 2.

The social eligibility requirements which might limit access to family planning services and which are not usually mentioned in the law are generally defined as marital status, age, sex, and parenthood (i.e., whether or not the potential patient has already borne a child). A standard clause of all federal regulations prohibits discrimination on the basis of race, religion, and national origin. The social eligibility requirements of the various programs are listed in Table 3.

None of the regulations or guidelines require parental consent for the provision of family planning services to minors except the Social and Rehabilitation Service's guidelines for Title IV-A programs which specify that “with respect to youths, voluntary consent includes parental consent if such is re-

Table 2. Financial Eligibility Requirements for Family Planning Services, by Program

Program	Financial Eligibility Requirements
Title X, Public Health Service Act	"All persons."* Priority to low-income individuals.
Title V, Social Security Act Maternal and Child Health Formula Grants Family Planning Project Grants	No mention of income requirements. At states' option. Persons of "low-income" or who "for other reasons beyond their control could not obtain comparable services."†
Title II, Economic Opportunity Act	Low-income individuals and residents of the area of the Community Action Program. Low-income level—\$4,000 for a nonfarm family of four.‡
Title IV-A, Social Security Act	All "appropriate" recipients of AFDC. At the states' option, past and present applicants, and past and potential recipients, and residents of low-income neighborhoods.§
Title XIX, Social Security Act	All persons on welfare. Others within federal statutory limits at the states' option.§
Military Medical Benefits Amendments	All active and retired members of the Uniformed Services and their dependents without income criteria.**

* Family Planning Services and Population Research Act of 1970, PL 91-572, December 24, 1970, Sec. 2(1).

† 42 CFR § 208.7(f).

‡ Community Action for Health: Family Planning, OEO, October 1967, pages 11-12. Also OEO Instructions No. 6004-1b, December 1, 1970.

§ 45 CFR II, § 220.52.

§ Characteristics of State Medical Assistance Programs under Title XIX of the Social Security Act, HEW-SRS (msa-pa 49-71) p. viii, ix, xi.

** Military Medical Benefits Amendments of 1966, as incorporated in Chapter 55, Title X, United States Code.

Table 3. Social Eligibility Requirements for Family Planning Services, by Program

Program	Social Eligibility Requirements
Title X, Public Health Service Act	"All persons." "Services will be made available without regard to religion, creed, age, sex, parity or marital status."**
Title V, Social Security Act Maternal and Child Health Formula Grants Family Planning Project Grants	Unstated. At states' option. "without regard to race, religion, national origin, maternity" [family size] or "marital status." Without regard to age and sex.†
Title II, Economic Opportunity Act	Discrimination is prohibited against "any potential beneficiary on the grounds of race, color, national origin and religion." Other criteria at the local agencies' option.‡
Title IV-A, Social Security Act	"without regard to marital status, age or parenthood."§
Title XIX, Social Security Act	Unstated. None other than those which determine eligibility under Medicaid generally. States may have additional limitations.
Military Medical Benefits Amendments	Unstated. None other than those which determine eligibility under the program generally.

* See Supplement. Federal Register Vol. 36, No. 179, September 15, 1971; Chapter I, Public Health Service, DHEW; Subchapter D—Grants, Part 59—Grants for Family Planning Services, § 59.5(2) p. 18166.

† 42 CFR § 208.7 (a) (b) (c) and Family Planning Services Project Grants of the National Center for Family Planning Services: Policies and Guidelines for Applicants, HEW-PHS-HSMHA, February 1971, p. 5.

‡ Community Action for Health: Family Planning, OEO, October 1967, D. Criteria for Recipient Eligibility—2. "Other eligibility criteria", p. 13.

§ 45 CFR § 220.21.

quired by state law.”²⁵ Under the Uniformed Health Services program, the written consent of the parent (s) or legal guardian is required for the sterilization of minors. The written consent of the patient, and spouse if married, is required for the surgical sterilization of adults. As discussed earlier, OEO policy formerly excluded but now approves of sterilization; as of the deadline for this study (September 1, 1971) however, OEO had not yet issued guidelines in regard to performance of surgical procedures. None of the other programs refer to sterilization.

Special Conditions, Prohibition of Coercion

Each of the federal program regulations and guidelines contains a specific statement prohibiting coercion, whether actual or implied. The language used is almost identical in each statute or regulation: For example the Title X statute provides:

The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided

through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.²⁶

The Uniformed Health Services Program does not make the voluntary participation requirement explicit in its regulations, but it may be implicit since medical personnel are not required to perform or participate in any surgical procedures that violate their moral, religious or professional beliefs. Such objections are considered a “lack of capability” to provide care and the patient can avail himself/herself of alternate facilities.

Federal Financial Support

For the Uniformed Services program, the federal government assumes the complete cost of the medical services provided under the program except for some small charges to the patient and \$50 yearly deductible per person (\$100 maximum per family).

Table 4. Local Share Requirements for Federally Supported Family Planning Services, by Program

Program	Local Share Requirements
Title X, Public Health Service Act	Unspecified. However “no grant shall be made for an amount equal to the total cost of the project.”* The capacity of the individual project to assume part of the cost is evaluated on an individual basis.
Title V, Social Security Act Maternal and Child Health Formula Grants	One half of the funds appropriated under MCH must be matched dollar for dollar by the states (fund A). The other half (fund B) is allocated to the states on the basis of a formula stated in the law, with no required matching. [†]
Family Planning Project Grants	The individual project must provide 25 percent of the cost to match the federal fund granted. [‡]
Title II, Economic Opportunity Act	The individual project must provide 20 percent of the costs to match the federal fund granted. [‡] The 20 percent may be “in kind.” [#]
Title IV–A, Social Security Act	The federal government reimburses the states at the rate of 75 percent of the cost of services provided. [§]
Title XIX, Social Security Act	The federal government reimburses the states on the basis of a formula which is inversely proportional to the states per capita income. Formula ranges from 50 percent to 83 percent federal share. ^{**}

In kind contributions are variously defined under different programs. Generally, they refer to services or program contributions other than cash.

* See Supplement. Federal Register §59.6(b).

† 42 CFR §200.23.

‡ 42 CFR §208.5.

Community Action for Health: Family Planning, OEO, October 1967, p. 25.

§ Title IV–A, SSA, as amended by PL 90–248, §403(a)(3)(A).

** Characteristics of State Medical Assistance Programs under Title XIX of the Social Security Act, DHEW–SRS (msa–pa 49, 71) p. xii.

For the other programs, local programs or states are held responsible for some portion or share of the costs. The various local share requirements are detailed in Table 4.

Federal funds are allocated to local programs in two ways:

- The federal government provides grants-in-aid to the states or local projects. The total amounts to be expended each year are determined by the ceiling of the authorization contained in the law and by the yearly appropriation of funds by Congress. The expenditure of these funds is "closed-ended." This is the situation with the Title X, Title V and OEO programs.
- The Title IV-A and Title XIX programs are known as "open-ended" since there is no ceiling on expenditures in the law and the federal government reimburses a stated portion of state expenditures at whatever level they occur.

Program Administration

The responsibility for the administration of each provision of the federal statutes is assigned by law or regulation to a specific agency of the government. For example, the Emergency Employment program is administered by the Bureau of Manpower of the Department of Labor. Compliance with postal regulations is ensured by four subagencies of the U.S. Postal Service. The Department of Defense administers the medical programs of the Army, Navy and Air Force, the Marines and, under certain conditions, the Coast Guard. (When the Coast Guard is not operating as part of the Navy, its medical program is administered by the Department of Health, Education and Welfare.) The family planning service programs of OEO are administered by the Family Planning Division of OEO's Office of Health Affairs.

DHEW, however, has multiple and complex responsibilities which were first reflected in the statement entitled *Programs in Family Planning—Needs, Roles and Responsibilities in the Department of Health, Education and Welfare* which the Secretary issued on January 31, 1968. This memorandum notes that "legislation has been enacted providing specific authority for the support of family planning programs, and departmental expenditures for the support of programs implementing the policy have been significantly increased" and outlines the broad responsibilities of the three major branches of the agency: the Office of Education (OE), the Social and Rehabilitation Service (SRS) and the Public Health Service (PHS).

The memorandum lists a large number of legislative authorities which could be drawn upon to implement the provision of family planning, and in an accompanying *Memorandum to Heads of Operating*

Agencies, the Secretary declared: "Family Planning has been established as a priority program within the Department. Each operating agency will utilize its existing authorities to the maximum to provide the development of family planning services."²⁷ The Secretary addresses the problem of coordination as follows:

The agencies of the Department are expected to provide for regular evaluation of their programs and reporting on programs. The Department, working with other departments and voluntary agencies, will develop a system of uniform reporting as a basis for evaluation of progress in the provision of quality services and for the determination of future policies and programs.

The Deputy Assistant Secretary for Population and Family Planning in the Office of the Assistant Secretary for Health and Scientific Affairs, will serve as the focal point for departmental policy and program coordination; will review and evaluate policies and programs; will conduct liaison with other departments; will cooperate with interested public and private groups; and will issue a statement of actions required to achieve these objectives within the Department.²⁸

On June 9, 1970, an *Organizational Plan for Population Activities in the Department of Health, Education and Welfare* was approved by Acting Secretary John G. Veneman. The plan "is predicated on the assumption that the responsibilities of the Deputy Assistant Secretary for Population Affairs are unique and of sufficient importance that special arrangements that go beyond the usual functions of a Deputy Assistant Secretary are necessary."²⁹ The provisions of the Organizational Plan follow:

1. To coordinate all activities in population and family planning in the Department of Health, Education, and Welfare under the direction of the Deputy Assistant Secretary for Population Affairs.
2. To delegate authority and responsibility for all activities in population and family planning within the health agencies of the Department of Health, Education, and Welfare to the Deputy Assistant Secretary for Population Affairs.
3. To delegate the guiding role in formulating the five-year plan and the annual budget as they related to HEW population activities, to the Deputy Assistant Secretary for Population Affairs . . .
4. To establish a formal public advisory committee to the Secretary, Department of Health, Education and Welfare. This Committee would be chaired by the Deputy Assistant Secretary for Population Affairs, and would report directly to the Secretary. It would assist in the development of policies and setting of priorities . . .
5. To enlarge the National Advisory Council of the National Institute of Child Health and Human Development . . .
6. To establish positions for 2 Special Assistants to the Assistant Secretary for Health and Scientific Affairs. One Special Assistant will concentrate his efforts in the area of population research; the other will concentrate his efforts in the area of family planning services.³⁰

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The Family Planning Services and Population Research Act of 1970 also attempted to coordinate scattered responsibilities by creating a statutory Office of Population Affairs to be directed by the Deputy Assistant Secretary for Population Affairs under the direct supervision of the Assistant Secretary for Health and Scientific Affairs. The law stipulates that the Deputy Assistant Secretary for Population Affairs is to be appointed by the Secretary of DHEW. Among other functions, the law requires him "to administer all federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of *grants* and *contracts* related to population research and family planning programs."³¹ These are the grants and contract programs under PHSA Title X and SSA Title V, and, for population research, PHSA Titles IV and X. It is also the responsibility of the Deputy Assistant Secretary "to coordinate and be responsible for the evaluation of the other Department of Health, Education and Welfare programs related to population research and family planning and to make periodic recommendations to the Secretary."³²

Under this arrangement, the Deputy Assistant Secretary has full line authority over the National Center for Family Planning Services, (NCFPS) of the Health Services and Mental Health Administration (HSMHA) and the Center for Population Research (CPR) of the National Institute for Child Health and Human Development (NICHD). The heads of these two operating agencies also report, respectively, to the Administrator of HSMHA and to the Director of NICHD and the Director of the National Institutes of Health (NIH).

For clarity, it may be best to refer to the table of organization (see Figure 1) to note specific program responsibilities and their assignments.

Title X and Title V programs are administered by HSMHA. Under HSMHA, the NCFPS, established in October 1969, is the "lead agency" for DHEW family planning services programs. It administers the project grant service programs established both under Title V of the Social Security Act and Title X of the Public Health Service Act. It is also responsible for the support and administration of operational research. Also under HSMHA, the Maternal and Child Health Service (MCHS) administers the major part of the programs authorized under Title V, among them the MCH state formula grant program and the Maternity and Infant Care (MIC) project grant program, both of which have some family planning components. The National Center for Health Statistics (NCHS) is responsible for the development and management of the family planning service reporting system mandated under Title X.

The Food and Drug Administration (FDA), like HSMHA, is responsible to the Assistant Secretary for Health and Scientific Affairs. As indicated earlier,

FDA reviews and approves new drugs, including contraceptives and sets other standards of quality for drugs and devices, (including IUDs, condoms and diaphragms). It also regulates labeling of drugs and the accuracy of these descriptions.

The Social and Rehabilitation Service (SRS) has overall responsibility for the administration of welfare programs, of Title IV-A and Title XIX (Medicaid) of the Social Security Act. The Administration of the Title IV-A program is entrusted to the Community Services Administration (CSA) of SRS. Specific aspects of Medicaid administration are assigned to the Medical Services Administration (MSA) and the Assistance Payments Administration (APA).

Program Expenditures

Prior to the enactment in 1970 of the Family Planning Services and Population Research Act, there were two major, clearly identifiable sources of funds for the support of family planning services: the project grant funds under Title V of the Social Security Act, and Title II of the Economic Opportunity Act. Expenditures under Title XIX and Title IV-A, of the Social Security Act, based as they are on reimbursements to the states, are difficult to identify and assess.

According to the *Senate Report* on the 1970 legislation:

Adequate funds to serve the women in need cannot be provided under existing legislation... It is unrealistic to expect much larger sums to become available under existing authorizations. S.2108 [the original Senate-passed bill] would provide a new source of project and formula grant funds. These new authorizations, when added to funds currently committed under title V, would make it possible to reach President Nixon's goal of serving all 5.4 million women in need within the next 5 years. To insure the development of services in both rural and urban areas, committee witnesses emphasized the need for both project and formula grants.³³

In FY 1971, project grant funds under Title V totaled \$29.5 million (out of an appropriation of \$32.5 million which included administrative expenses as well as research and demonstration and other activities). OEO had a funding level of \$18.8 million for family planning project grants. The new Title X legislation authorized additional funds totalling \$42.75 million for family planning services and service related activities in FY 1971, and in FY 1972 and FY 1973 authorizations for services rose to \$78 million and \$115.25 million, respectively. (See Table 5).

Only \$6 million of the funds authorized for 1971 were requested and provided in the second supplemental appropriation for 1971. These funds were to be expended prior to December 31, 1971.

Table 5.

New Authorizations under PL 91-572 (Title X, PHSA) (in millions of dollars)

Family Planning Services	FY 1971	FY 1972	FY 1973
Project Grants:	30	60	90
Formula Grants:	10	15	20
Training:	2	3	4
Information and Education:	0.75	1	1.25
Population Research (including operational research)	30	50	65

In FY 1972, the Administration requested, and the Congress appropriated, \$90.9 million for family planning programs under the combined authorities of Title V of the Social Security Act and Title X of the Public Health Service Act, both of which are administered by the National Center for Family Planning Services. This amount included some \$10 million for the support of OEO programs transferred to DHEW without concomitant financial support. The contribution of Title V funds to the family planning budget (\$27 million) was slightly lower than it had been in the previous year (\$29.5 million). The estimated expenditures for family planning through other federal programs are detailed in Table 6.

As mentioned earlier, it is extremely difficult to identify expenditures under Title IV-A and Title XIX. Two separate studies, one by the Center for Family Planning Program Development (CFPPD) in 1969³⁴ and the other by the City University of New York (CUNY) in 1970³⁵ attempted to assess the number of patients served under the programs and the possible amount of expenditures at the state

level. Of the 43 states and territories with approved Title XIX plans at the time of the CFPPD study, 33 reported that they could neither determine nor estimate the number of patients who had received family planning services during the year. Two jurisdictions were positive that no family planning services were provided under the program.

Three states provided total estimates, and two partial estimates. Program directors in another two states indicated that an estimate could have been made, but either had not been made or was not available at the time. In the nine states which could provide *some* estimates, it was not clear whether both medical services and drugs had been paid for under the program. The total number of patients identified as having received some service was less than 25,000. This is not to say, of course, that no services were provided in the states which could not provide estimates. (See Federal Laws and Policies Profile on Title XIX).

The CUNY Survey was designed to assess the implementation of the requirement of Title IV-A of the Social Security Act that the states provide family

Table 6.

Federal Budget for Family Planning Services Not Administered by the National Center for Family Planning Services (in millions of dollars)

Authorization Legislation	Estimated FY 1971	Estimated FY 1972
The Economic Opportunity Act as amended in 1967, designating family planning a 'special emphasis' program with administrative and funding priority.	18.8	24.0
Social Security Act, as amended by P.L. 90-248, authorizing Maternity and Infant Care program.	4.7 (for family planning services)	4.2 (for family planning services)
Social Security Act, as amended by P.L. 90-248, requiring that states make progress in provision of family planning services.	11.7 (of which 9 is specifically earmarked; remainder represents estimated expenditure)	11.7 (of which 9 is specifically earmarked; remainder represents estimated expenditure)

Note: Sources for budget estimates include Congressional Committees, the Health Services and Mental Health Administration, the U.S. Budget, the Office of Economic Opportunity, and various HEW and OEO policy directives and publications.

planning service for all appropriate welfare recipients. Since the states are permitted to utilize both Title IV-A and Title XIX funds to finance these family planning services, the survey included a number of questions aimed at elucidating the extent to which states made use of either mechanism to meet the mandate of the law (see Federal Laws and Policies Profile on Title IV-A). This survey, like the CFPPD Survey, found that the states had great difficulty in identifying funds expended for family planning services. Only 13 states provided estimates for FY 1969 expenditures, and only 12 could project their expenditures for FY 1970. Title IV-A appeared little used as a financing mechanism for the purchase of family planning services. Less than \$109,000 could be identified as family planning expenditures under Title IV-A by the 13 states in FY 1969. Projections for FY 1970, through both Title XIX and Title IV-A for services and for drugs and devices combined amounted only to \$2,543,898.³⁰ Again, states which provided either no estimates or partial estimates cannot be assumed to provide no services, but there is no way to measure the level of their program efforts. In view of the many restrictions involved in providing reimbursements under Medicaid, a high service level and a correspondingly substantial level of expenditures under that program appear unlikely. In addition, many states (particularly the more populous ones) have had to cut back substantially on their Medicaid programs.

The DHEW Five-Year Plan for Population Research and Family Planning Services

The Family Planning Services and Population Research Act of 1970 requires that DHEW prepare and submit to the Congress a five-year plan and an annual report with regard to family planning services and population research. (See Federal Laws and Policies Profile on Title X for details of the statutory requirements for the Plan).

The five-year plan was submitted to the Congress by DHEW on October 12, 1971. It estimates that there will be 6.6 million low-income women in the nation in need of family planning services by 1975.

The five-year plan notes that substantial progress has been made toward alleviating that need through federally supported programs and the private sector:

Available nine-month service statistics from the National Center for Health Statistics and Planned Parenthood-World Population, covering about half of all identified programs, were projected to yield a tentative estimate that all publicly and privately-financed organized programs are likely to have had 1.8 million active patients by the end of FY 1971. This estimate implies that organized programs have served an estimated 2.2 million total patients during the period ending June 30, 1971. In addition, the number of low-income patients served by private physi-

cians is estimated at .7 million. Thus it is estimated that a total of 2.9 million low-income patients will have been served by the end of FY 1971, in both sectors. Since the number of low-income women estimated to require family planning services in FY 1975 is 6.6 million, the plan seeks to articulate service goals for each year that will build, by FY 1975, the capacity to serve at least 3.7 million additional patients.³⁷

The plan points out that

... At the end of 1969, organized programs of some sort were identified in 1,436 counties, while no service could be identified in the remaining 1,636 counties ... The services were provided by 1,983 agencies: 505 public and voluntary hospitals, 1,177 local health departments, 146 Planned Parenthood Affiliates and 155 other agencies reported that they participated, either directly or jointly in the provision of subsidized family planning services. ... While a significant number of health institutions thus already participate in the delivery of family planning services, many hospitals and health departments do not. In the next five years, programs in current provider agencies will have to be strengthened and the rest of the nation's health agencies will need to be encouraged to participate.³⁸

The plan provides projections of the total number of patients who would need to be served nationally in each year through FY 1975 by each type of service provider: hospitals, health departments, voluntary agencies and private physicians. Hospital programs are projected to "almost quadruple" their caseloads while health department caseloads would double, as would those of private physicians. Voluntary agency services are projected to increase at a slightly lower rate.³⁹ (See Table 7)

The plan estimates that approximately "...90,000 staff members, including administrators, nurses, clinic aides and outreach workers" will be needed to staff the expanded programs, in addition to the services of physicians. It estimates that more than 80,000 of these would work part-time in family planning. The plan indicates that "priority in training will be given to preparation of full-time staff."⁴⁰

The plan recognizes the need for improved educational services directed at patients and particularly that:

... It is now recognized that the prevention of school-age pregnancies is dependent to some extent on providing young persons with adequate information about reproduction, contraception, and the consequences of pregnancies occurring too early in life.

But it adds:

Beyond the educational activities directly supporting the delivery of family planning services, there is need to develop and make readily available information about population growth. At present, there is little public awareness of the meaning or the causes of rapid population growth. To many people, the problems of population growth are something remote that threaten other peoples. Problems associated with population growth have often been presented with exaggeration.⁴¹

Table 7.

**Projected Number and Distribution of Family Planning Patients,
by Delivery Agency, 1970-FY 1975
(Numbers in thousands)**

Agency	1/1/70- 6/30/71		FY 1972		FY 1973		FY 1974		FY 1975	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Hospitals	615	21.1	1,036	27.1	1,457	30.7	1,878	33.2	2,299	34.9
Health Departments	906	31.3	1,139	29.8	1,373	29.0	1,606	28.4	1,839	27.9
Voluntary Agencies	647	22.3	755	19.8	864	18.2	973	17.2	1,082	16.4
Private MDs	729	25.2	887	23.2	1,045	22.1	1,203	21.3	1,361	20.7
Total**	2,897	99.9*	3,818	99.9*	4,739	100.0	5,660	100.1*	6,581	99.9*

* Does not add to 100% because of rounding.

** Summed prior to rounding.

(From Table B, Report of the Secretary of HEW, op. cit., p. 94)

The five-year plan estimates of the national costs of programs for increased and expanded family planning services appear in Table 8.

These cost estimates are for total federal, state, local and private expenditures. They do not provide, as required by the law, an estimate of the amount of federal contribution needed to accomplish the goals established by the plan. However, the Senate subsequently received these estimates on December 1, 1971. (Table 9.)

It must be noted, however, that Secretary Richardson's letter of transmittal added the following explanation:

I believe it is important that you have an explanation of these charts to avoid any misleading interpretations.

We believe that these costs need to reflect the impact of pending legislation that will drastically alter the way we provide and pay for family planning services. These legislative proposals include: H.R.1; the Family Health Insurance Plan; the National Health Insurance Standards Act; and anticipated changes in Title V of the Social Security Act.

We believe these proposed legislative changes will have a significant impact on the financing of family planning services. Because they do not take any of this into account we believe the Federal dollar distribution as shown in these tables is meaningful only for the current year—FY 1972.⁴²

Table 8.

**Range of Estimated Costs
for Subsidized Family Planning Services in The United States ***
(in millions of dollars)

Program Components	Fiscal Year				
	1971	1972	1973	1974	1975
Delivery of Services	140-175	200-230	250-285	305-340	360-395
Manpower Development	7-8	8-9	8-9	9-10	0-10
Operational Research, Planning and Evaluation	4-5	8-9	10-11	14-16	18-22
Information and Education **	3-4	3-4	4-5	5-6	5-7
TOTALS	154-192	219-252	272-310	332-372	392-434

* Federal agencies and other national institutions, organizations, and industries in the United States combined.

** Also includes population education activities authorized under P.L. 91-516 and Section 1005 of P.L. 91-572.

(From Table II, Report of the Secretary of HEW, op. cit., p. 27)

Table 9.

Summary of Major Sources of Federal Funding of Family Planning Services, Projected through 1975
(in millions of dollars)

	FY 1971			FY 1972			FY 1973			FY 1974			FY 1975		
	Delivery of Services	Other Supporting Programs	Total	Delivery of Services	Other Supporting Programs	Total	Delivery of Services	Other Supporting Programs	Total	Delivery of Services	Other Supporting Programs	Total	Delivery of Services	Other Supporting Programs	Total
1 National Center for Family Planning Services	35	5	40	82	9	91	133	13	146	181	19	199	225	25	250
2 Maternal and Child Health Services	16	1	17	16	1	17	19	1	20	21	1	22	24	1	25
3 Other HEW*	9	1	10	12	2	14	14	2	16	19	3	22	24	3	27
4 Total HEW	60	7	67	110	12	122	166	16	182	221	23	243	273	29	302
5 Office of Economic Opportunity	25	1	26	24	1	25	24	1	25	24	1	25	24	1	25
6 Total Federal Gov't.	85	7	93	13	134	147	190	17	207	245	23	268	298	29	327

Totals may not add due to rounding

* Includes family planning programs in the Indian Health Service, the Bureau of Health Manpower Education, the National Center for Health Statistics, and the Social and Rehabilitation Service (Title IV-A, Aid to Families with Dependent Children and Title XX, Medicaid).

Source: Letter from HEW Secretary Elliott Richardson to Senator Alan Cranston, Chairman, Special Subcommittee on Human Resources of the Senate Labor and Public Welfare Committee, in *Hearing, Declaration of U.S. Policy on Population Stabilization by Voluntary Means*, 1971; GPO, 1972, p. 422

COMMISSION ON POPULATION GROWTH AND THE AMERICAN FUTURE

In 1970 Congress established a Commission on Population Growth and the American Future "to conduct and sponsor studies and research and make . . . recommendations . . . to provide information and education to all levels of government . . . and [to the American] people regarding a broad range of problems associated with population growth and their implications for America's future." PL 91-213 became law on March 16, 1970.

The law provided that the Commission be composed of two members each of the Senate and House of Representatives and not to exceed twenty members appointed by the President. The law further provided that the Commission submit its final report two years after enactment of the law and that the Commission cease to exist 60 days after submission of its final report.⁴³

Footnotes to "Federal Laws and Policies"

1. Memorandum from Surgeon General Thomas Parran to State Health Departments, 1942.
2. House Appropriations Hearings, DHEW, 1967, page 988.
3. Emergency Employment Act of 1971, PL 92-54, July 12, 1971, § 4.
- 3a. 45 CFR II Social and Rehabilitation Service, DHEW, § 249.10 (b) (15) (i).
- 3b. *Federal Register*. "Title 32, National Defense, Chapter V; Department of the Army, Part 577—Medical and Dental Attendance, Uniformed Services Health Benefits Program" April 8, 1971, page 6721.
4. Title V, SSA, § 501.
5. Title V, SSA, § 508 (a) (3).
6. Economic Opportunity Act, as amended. Title II § 201 (a).
7. Family Planning Services and Population Research Act of 1970, PL 91-572, December 24, 1970, § 2 (1).
8. Op. Cit. EOA. Title II § 201 (a).
9. Social Security Act, as amended by PL 90-248, 1967. Title IV § 402 (a) (14) and (15).
10. World Leaders Declaration on Population, *Studies in Family Planning*, No. 16; Population Council, 1967.
11. 45 CFR II Social and Rehabilitation Service (Assistance Program), DHEW, § 249.10 (b) (15) (ii).
- 11a. *Ibid.*
12. *Children's Bureau Health Grants Manual*, 13-1.6, Part II A.
13. Op. Cit. *Federal Register*: note 3.
14. 45 CFR II § 220.21.
15. *Community Action for Health: Family Planning*, OEO, October 1967, page 16.
16. See Supplement. *Federal Register*, Vol. 36, No. 179, September 15, 1971. "Title 42—Public Health, Chapter I, Public Health Service, DHEW; Subchapter D. Grants, Part 59—Grants for Family Planning Projects, § 59.5 (1). Regulations were published after the close of this study. The Regulations are reported by DHEW to be under revision in certain aspects which do not appear to be relevant to this portion of the analysis.
17. *Family Planning Services Project Grants of the National Center for Family Planning Services; Policies and Guidelines for Applicants*, HEW-PHS-HSMHA, February 1971; page 3.
18. Op. Cit. *Community Action for Health*, pages 16-17.
19. *Ibid.*, page 16.
20. See Supplement, Op. Cit. *Federal Register*, Vol. 36, No. 179, September 15, 1971.
21. Op. Cit. *Family Planning Services Project Grants*, pages 3-4.
22. See Supplement, September 15, 1971 *Federal Register*, § 59.5 (b).
23. Op. Cit. Supplement, *Federal Register*, 1971.
24. Op. Cit. *Family Planning Services Project Grants*, 1971, p. 4.
25. *Guides on Federal Regulations Governing Service Programs for Families and Children: Title IV, Parts A and B, Social Security Act, Community Services Administration, SRS, DHEW, 1971, § 220.21, page 28.*
26. Op. Cit. PL 91-572, Sec. 1007.
27. Report of the Secretary of Health, Education and Welfare Submitting Five-Year Plan for Family Planning Services, October 12, 1971. Prepared for the Special Subcommittee on Human Resources of the Senate Committee on Labor and Public Welfare, page 550.
28. *Ibid.*, page 551.
29. *Ibid.*, page 558.
30. *Ibid.*, pages 558-560.
31. Op. Cit. PL 91-572, § 4 (1).
32. *Ibid.* § 4 (6).
33. Senate Labor and Public Welfare Committee Report on S.2108, July 7, 1970, No. 91-1004, page 10.
34. J. I. Rosoff, *Family Planning, Medicaid and the Private Physician*, Center for Family Planning Program Development Publication No. 9, 1969.
35. J. Goldman and L. S. Kogan, "Public Welfare and Family Planning," *Family Planning Perspectives* Vol. 3, No. 4, October 1971, p. 19.
36. *Ibid.*
37. Op. Cit. Report of the Secretary of HEW p. 86; Note also, "Since the recordkeeping systems underlying these projections do not typically ask for income data, it is quite possible that some of the patients reported served have incomes above the 150%-of-poverty line which is being used in this plan to define medical indigency and to estimate the population in need. Thus the achieved service levels estimated for FY 1971 should be interpreted with caution since not all patients served will be among those defined in the universe of need."
38. *Ibid.* pp. 83, 84.
39. *Ibid.* p. 93.
40. *Ibid.* p. 16.
41. *Ibid.* p. 20.
42. Letter from Secretary Richardson to Sen. Cranston. See, Source, Table 11.
43. On March 27, 1972, John D. Rockefeller 3d, Chairman of the Commission on Population Growth and the American Future appointed pursuant to PL 91-213, transmitted to the President and Congress the Final Report of the Commission. The Report, *Population and the American Future*, which contains a broad range of findings and recommendations, has been published by the Government Printing Office.

**Profiles: Federal Laws and Policies on Family Planning,
Contraception and Voluntary Sterilization**

FAMILY PLANNING SERVICES AND POPULATION RESEARCH ACT (TITLE X, PUBLIC HEALTH SERVICE ACT-PL 91-572)

A. General Purposes and Provisions of the Law

The Family Planning Services and Population Research Act (PL 91-572), was signed into law on December 24, 1970. Its two major purposes are to "assist in making comprehensive voluntary family planning services readily available to all persons desiring such services," and to "evaluate and improve the effectiveness of family planning services programs and of population research."¹ (Population research activities are beyond the scope of this study.) The Senate Report on the Act further explains these purposes:

This legislation is designed to make comprehensive, voluntary family planning services, and information related thereto, readily available to all persons in the United States desiring such services; to provide greatly increased support for biomedical, behavioral and operational research relevant to family planning and population; to develop and disseminate information on population growth; and to coordinate and centralize the administration of family planning and population research programs conducted by the Department of Health, Education, and Welfare."²

To implement the service program, the law authorizes a new three-year program of grants and contracts to be administered by DHEW in the following areas:

- Project grants and contracts may be made to public agencies and nonprofit private organizations to "assist in establishing . . . voluntary family planning projects." The law also requires the Secretary, in making grants, to "take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance."³

- "Formula" grants may be made to state health agencies for planning, establishing, and conducting family planning service programs. The law requires that the state health agency submit a state plan for a coordinated and comprehensive program of family planning services before it may receive a grant under this program. Funds are to be allocated to the states on the basis of population and the financial need of the state.

- Training grants may be made to public or nonprofit private entities, and contracts may be let with

public or private agencies and individuals for training of the manpower needed to conduct family planning programs.

- Population research grants may be made to public agencies and nonprofit private organizations, and contracts may be let with public or private entities and individuals.

- Grants may be made to public agencies or private nonprofit organizations and institutions, and contracts may be let with public or private agencies or individuals for the purpose of developing and making available family planning and population growth information.

1. **Special Requirements:** The law requires DHEW to prepare and submit to the Congress a five-year plan and an annual report with regard to family planning services and population research. The law describes the five-year plan requirements in regard to provisions of family planning service as follows:

... a report to the Congress setting forth a plan, to be carried out over a period of five years, for the extension of family planning services to all persons desiring such services, for family planning and population research programs, for training of necessary manpower for the programs authorized by title X of the PHSA and other Federal laws for which the Secretary has responsibility, and for carrying out the other purposes of the act.

The law requires that the plan:

... , at a minimum, indicate on a phased basis—

- (1) the number of individuals to be served by family planning programs under title X of the Public Health Service Act and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information educational materials to be developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;
- (2) an estimate of the costs and personnel requirements needed to meet these objectives; and
- (3) the steps to be taken to establish a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department of Health, Education, and Welfare shall be based.⁴

The law further requires DHEW to submit the five-year plan no later than six months after enactment of the law, or by June 24, 1971, and an annual report

by January 1 of each year thereafter for a period of "five years." The annual reports are to:

compare results achieved during the preceding fiscal year with the objectives established for such year under plan; indicate steps being taken to achieve the objective during the remaining fiscal years of the plan and any revisions necessary to meet these objectives; and make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan.⁵

The law places two conditions upon the use of funds appropriated under the Act. One relates to "voluntary participation" in the program and the other prohibits the use of funds for "programs where abortion is a method of family planning."⁶ The section on voluntary participation states:

The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.⁷

In reference to abortion, the House-Senate Conference Committee reported:

It is and has been the intent of both houses that the funds authorized under this legislation be used only to support preventive family planning services, population research, infertility services, and other related medical, informational, and educational activities. The conferees have adopted the language contained in section 1008, which prohibits the use of such funds for abortion, in order to make clear this intent. The legislation does not and is not intended to interfere with or limit programs conducted in accordance with state or local laws and regulations which are supported by funds other than those authorized under this legislation.⁸

2. Eligibility for Services: The law does not contain eligibility requirements for the receipt of services and information. Services are to be made available to all persons desiring such services. There are no restrictions as to age, marital or parental status or income. The law specifically prohibits fees charged for services to persons of low income (except for third party payments—such as Medicaid). However, grants and contracts may be made only upon receipt of satisfactory assurances that:

... Priority will be given in such project or program to the furnishing of such services to persons from low-income families; and

For purposes of this subsection, the term 'low-income family' shall be defined by the Secretary in accordance with such criteria as he may prescribe.⁹

Finally, with regard to these programs, the law stipulates that grants and contracts may be made "in accordance with such regulations as the Secretary may

promulgate."¹⁰ Regulations were published after the September 1971 deadline for this study. At the time this report was completed, the guidelines were reported by DHEW as undergoing "reassessment."¹¹

3. Federal Financial Support: The law does not require grantees or contractees to match any share of federal supporting funds. A total of \$129 million is authorized for the Title X programs in FY 1972; and \$180,250,000 is authorized for FY 1973. It is allocated in the following manner:

	FY 1972	FY 1973
Project Grants	\$60 million	\$90 million
Formula Grants	15 million	20 million
Training	3 million	4 million
Information and Education	1 million	1.25 million
Population Research (including operational research)	50 million	65 million

The *Senate Report* on the first Senate-passed version of the Act stated, with regard to funds provided under the law for family planning services:

Adequate funds to serve the women in need cannot be provided under existing legislation. The proposed project grant budget for fiscal year 1971 is \$29.5 million. It is unrealistic to expect much larger sums to become available under existing authorizations. S.2108 would provide a new source of project and formula grant funds. These new authorizations, when added to funds currently committed under title V, would make it possible to reach President Nixon's goal of serving all 5.4 million women in need within the next 5 years. To insure the development of services in both rural and urban areas, committee witnesses emphasized the need for both project and formula grants.¹²

4. Expenditures and Administration: The FY 1972 appropriations provided the funds requested by the Administration for various activities under Title X. Close to the full amount of the authorization was requested for project grants for family planning services, although, as pointed out earlier, some \$10 million of the new Title X funds were utilized to substitute for funds previously available through OEO or Title V. The full amount authorized under the legislation (\$8 million) was requested for training, and \$2.6 million was budgeted for operational research. No funds were requested for state formula grants.

The law instituted significant administrative changes in DHEW. It established an Office of Population Affairs to be directed by a Deputy Assistant Secretary for Population Affairs, under the direct supervision of the Assistant Secretary for Health and Scientific Affairs. The law stipulates that the Deputy Assistant Secretary for Population Affairs is to be appointed by the Secretary.

The purpose of the Office of Population Affairs, as defined in the law, is to serve "as a primary focus within the Federal Government on matters pertaining to population research and to family planning, through which the Secretary of HEW . . . shall carry out the purposes of this Act."¹³

The law outlines several specific functions and responsibilities of the Deputy Assistant Secretary for Population Affairs. These include:

(1) to administer all Federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of grants or contracts related to population research and family planning programs;

(2) to administer and be responsible for all population and family planning research carried on directly by the Department of Health, Education, and Welfare or supported by the Department through grants to, or contracts with, entities and individuals;

(3) to act as a clearinghouse for information pertaining to domestic and international population research and family planning programs for use by all interested persons and public and private entities;

(4) to provide a liaison with the activities carried on by other agencies and instrumentalities of the Federal Government relating to population research and family planning;

(5) to provide or support training for necessary manpower for domestic programs of population research and family planning programs of service and research; and

(6) to coordinate and be responsible for the evaluation of the other Department of Health, Education, and Welfare programs related to population research and family planning and to make periodic recommendations to the Secretary.¹⁴

The *House Report* on H.R. 19318 contains this statement with regard to the Deputy Assistant Secretary for Population Affairs:

In October 1969, the National Center for Family Planning Services [NCFPS] was established within the Health Services and Mental Health Administration. [HSMHA] In June . . . [1970] . . . full line authority for directing these two agencies . . . and for coordinating the other activities of the Department in this area was delegated to the Deputy Assistant for Population Affairs.¹⁵

Therefore, NCFPS, (designated by DHEW as the "lead agency" for all HSMHA family planning activities and the agency responsible for family planning services project grants under Title V of the Social Security Act (see Title V Profile, below) is responsible for the administration of all service programs under Title X of the Public Health Service Act

(see Title X Profile, below) and for all research on program operations. Biomedical research, including research on contraceptive development, and social research related to population are administered by the Center for Population Research of the National Institute for Child Health and Human Development. (CPR-NICHD-DHEW). The NCFPS administers the services and services related provisions of Title V and Title X (PL 91-572) through its headquarters in Rockville, Maryland, and through its Regional Family Planning Officers. Both the Deputy Assistant Secretary for Population Affairs and the Administrator of HSMHA have line authority over the NCFPS. In addition, the DHEW Regional Health Directors, who have line authority over the Regional Family Planning Officers and also have authority to approve Title X family planning services projects, report to the Administrator of HSMHA. The Regional Family Planning Officers report to the Directors of NCFPS as well as to the Regional Health Directors. Therefore, there are many 'shared' relationships and responsibilities among DHEW family planning programs.

Footnotes to "Family Planning Services and Population Research Act"

1. Family Planning Services and Population Research Act of 1970, Title X, Public Health Service Act (PL 91-572) . § 2.
2. Senate Report 91-1004, Calendar No. 1008, Senate Labor and Public Welfare Committee, July 7, 1970, p. 3 (to accompany S. 2108, the original Senate version of the Family Planning Service and Population Research Act) .
3. Op. Cit., Title X, PHSA § 1001 (b) .
4. Ibid., § 5 (a-b) .
5. Ibid., § 5 (c) .
6. Ibid., § 1008.
7. Ibid., § 1007.
8. Conference Report to accompany S.2108; House Report 91-1667 Dec. 3, 1970, pp. 8, 9.
9. Op. Cit. Title X, PHS Act, § 1006 (c) .
10. Ibid., § 1006 (a) .
11. Letter from Louis M. Hellman, M.D., Deputy Assistant Secretary for Population Affairs, DHEW to Alan F. Guttmacher, M.D., President PP-WP, Oct. 18, 1971.
12. Op. Cit., Senate Report, p. 10.
13. Op. Cit., Title X, § 2 (8) .
14. Ibid., § 4.
15. House Report #91-1472, September 26, 1970, p. 10, Committee on Interstate and Foreign Commerce (to accompany H.R. 19318) .

MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES — TITLE V, SOCIAL SECURITY ACT, AS AMENDED

A. General Purposes and Provisions of the Law

The purpose of Title V of the Social Security Act is to improve the health of mothers and children and to expand and improve services for crippled children. With regard to maternal and child health the law states as its purpose:

For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State,

(1) services for reducing infant mortality and otherwise promoting the health of mothers and children; ...¹

These purposes are to be implemented by making special allotments of funds to the states on the basis of a formula described in the law, by supporting project grants in specific areas such as maternity and infant care (MIC) and by making grants for research and demonstration "relating to maternal and child health services . . . which show promise of substantial contribution to the advancement thereof."²

All three programs are administered by the Maternal and Child Health Service (MCHS) of the Health Services and Mental Health Administration (HSMHA). However, the administration of the special project grants for family planning services (see below) has been delegated to the National Center for Family Planning Services (NCFPS), another subagency of HSMHA. (See Title X Profile.)

1. Family Planning Provisions: In 1967, Congress added a requirement to Title V to the effect that "not less than six percent of total maternal and child health appropriations" be earmarked for family planning services, supported through all three channels mentioned above, although the law did not assign a specific percentage to each. In addition, the law was changed to require the states, in their Maternal and Child Health (MCH) plans (see below) to "provide for the development of demonstration services (with special attention to dental care for children and family planning services for mothers) in needy areas and among groups in special need."³ The law also states:

...no payment shall be made concerning the State plan to any State unless the State makes a satisfactory showing that it is extending the provision of services, including services for dental care for children and family planning

for mothers . . . with a view to making such services available by July 1, 1975, to children and mothers in all parts of the State.⁴

Another 1967 change was the inclusion in the law of specific authorization for family planning project grants as part of "Special Project Grants for Maternity and Infant Care," which now reads:

In order to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality, the Secretary is authorized to make . . . grants to the State health agency of the State and, with the consent of such agency, to the health agency of any political subdivision of the State, and to any other public or nonprofit private agency, institution, or organization, to pay not to exceed 75% of the cost . . . of any project for the provision of—

- (1) necessary health care to prospective mothers . . .
- (2) necessary health care to infants during their first year . . .
- (3) family planning services . . .⁵

No specific language concerning family planning activities was added to the research and training provisions of the law although the overall requirement that not less than six percent of Maternal and Child Health appropriations be for family planning authorizes the support of family planning research.

B. MCH State Allotment or Formula Grant Program

The MCH state formula grant program is governed by the directions contained in two major documents: the federal regulations, which have the strength of law, and the guidelines manual. The regulations are found in the chapter of the *Code of Federal Regulations* entitled "Children's Bureau," which outlines general rules for the MCH program—its state allotment and its state plan. These regulations, for the most part, simply repeat the law. The guidelines manual, entitled *Children's Bureau Health Grants Manual*, provides a further statement of DHEW requirements for approval of the state plan by the Regional Health Directors of DHEW. The approval of such a plan, to be submitted to DHEW yearly, is a prerequisite for the receipt, by the state, of its federal allotment of funds under this program. Under "Goals and Objectives," the manual recommends

that the state plan include a statement in which "goals should be defined in terms which allow measurement of progress toward achievement, e.g. . . . to increase the availability of family planning services."⁶ In addition, it makes explicit the requirement of the law regarding demonstration services, stating: "Inclusion of such demonstrations is a condition for plan approval. Describe plans for demonstrations in family planning . . ."⁷

1. Services to be Provided: Neither the statute, the *Code*, nor the *Manual* specify the medical, educational, or social services to be included as components of a family planning service program. The *Manual* indicates, under "MCH Program Scope and Content," that "family planning and counseling activities [are] related to the goals of the legislation for the maternal and child health program." It states, however, that "the scope of a program may be less or more than indicated by [the] examples which serve only as guides to content."⁸ Nine examples are mentioned ranging from screening tests for inborn errors of metabolism to hospitalization of maternity patients and specialized services for infants at high risk.

Both the *Code* and the *Manual* state that it is a goal of the MCH program to make family planning and other services available "as widely as possible by 1975" throughout the states. To this end, the states are allowed to utilize the services available through other public agencies or, if necessary, to purchase services from private or public agencies. The *Manual* states that the method by which such purchase of service or cooperative arrangements with other agencies is achieved must be described in the state plan.⁹ The state plan must also:

describe plans for cooperation between the MCH and CC programs and the State agency administering or supervising the administration of the State plan approved under Title XIX of the Social Security Act in providing care and services for mothers and children.¹⁰

In addition to the state plan, the state agency must submit an annual report to DHEW to show progress in meeting the objectives of the plan. With regard to these reports, the *Manual* states: "Particular attention should be given to reporting progress in new activities and areas of emphasis such as family planning, dental care, extension of services . . ."¹¹

2. Special Conditions: Prohibition of Coercion: The statute and the *Code* contain specific prohibitions against coercion in relation to the use of family planning services. The state plan must contain assurances that:

. . . acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan.¹²

In addition, there is a standard provision common to all MCH services which deals with "Observances of Religious Beliefs."

Nothing in this title shall be construed to require any State which has any plan or program approved under, or receiving financial support under, this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan or program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.¹³

3. Eligibility for Services: Neither the statute itself nor the regulations in the *Code* state any specific eligibility requirements for family planning services. Since there is no mention of age, income, or geographical requirements, it may be assumed that state agencies may determine their own criteria.

4. Federal Financial Support: MCH State formula funds are allocated on the following basis: the state agency receives a \$70,000 basic grant plus an additional amount based on the number of live births in the state. Together, the additional amount and the basic grant equal one-half of the total amount of funds appropriated under this provision for MCH services.¹⁴ This first half is known as "Fund A" and must be matched dollar for dollar by the state.

The other half of the funds is allotted on the basis of urban and rural births in each state and on the basis of state per capita income. Again, no state receives less than \$70,000, and rural live births are given twice the weight of urban births. Funds vary inversely with state per capita income. This second half does not require matching funds from the state and is known as "Fund B." Of this second half, the law specifies that not more than 25 percent may be used for grants to state agencies and public or private nonprofit colleges and universities for special projects which have regional or national significance and which may contribute to the advancement of maternal and child health. The regulations further specify that an amount shall be reserved for special projects for the mentally retarded child.

5. Administration and Expenditures: The Title V—State Formula Grant Program is administered by MCHS—HSMHA with the assistance of the DHEW Regional Health Directors under reorganization plans printed in the *Federal Register* on September 23, 1969, September 16, 1970 and March 5, 1971. The program was formerly administered by the Children's Bureau of the Social and Rehabilitation Service of DHEW.

In FY 1971, and again in FY 1972, DHEW requested and the Congress approved a \$9 million

special allocation of MCH funds to be earmarked for family planning activities. These funds were allocated to the states on a formula basis.¹⁵ In addition, it is estimated by the MCHS that the states spent \$3.5 million of their general MCH formula grants funds for various family planning activities.

C. Special Project Grants for Maternity and Infant Care

The purpose of the Maternity and Infant Care (MIC) program is to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality (See General Purposes and Provisions of Title V, above). In order to accomplish this, the program provides financial support for comprehensive maternity and infant care services such as prenatal and maternity care, postpartum and interconceptional care and infant care. Family planning services are now considered part of comprehensive maternity care and, as such, are generally included in the MIC programs.

The MIC project grant program is administered by the MCHS which estimates an annual level of expenditures for family planning services through all local programs of \$4.7 million in FY 1971 and \$4.2 million in FY 1972.¹⁶

1. Special Project Grants for Family Planning Services: Authority was provided under the 1967 amendments to Title V of the Social Security Act for the support of specific family planning projects under the general rubric of "Special Project Grants for Maternity and Infant Care" (Title V, § 508 (a) (3) — See Family Planning Provisions of Title V, above.)

The purpose of the family planning services program is to make:

family planning services available to persons of low-income who want such services and who are without access to such services and to other persons who for other reasons beyond their control cannot obtain comparable services . . . The family planning services program will provide information, services, and supplies in order to promote maternal health and to insure that individuals have freedom of choice to determine the spacing of their children and the size of their families.¹⁷

The *Guidelines* list four objectives for the project grants program:

1. reducing maternal and infant morbidity and mortality;
2. reducing the incidence of illegal abortions;
3. providing an entry to general health care services to individuals and families who previously did not have access to such services; and
4. providing continuity of medical supervision for women of childbearing age.¹⁸

2. Services to be Provided: *The Code of Federal Regulations* prescribes the following components which

must be included in any project grant for family planning services:

- Projects must include "counseling and interpretation to individuals of the services provided."
- Family planning medical services are required to be "under the direction and responsibility of a physician with special training or experience in family planning."
- Projects must be "designed to assure comprehensiveness and continuity in the health management and supervision of project patients with respect to family planning services."¹⁹

In addition the *Code* defines the various requirements for the medical components which must be included in family planning services. The regulations state:

A variety of medically approved methods of family planning, including the rhythm method, must be available to persons to whom family planning services are offered and provided.

Diagnostic and treatment services for infertility must be provided for in the family planning project.²⁰

These requirements are further amplified in the *Guidelines*, which indicate:

Medical services that must be provided as a minimum to each patient shall include:

- a variety of medically approved methods of contraception, including, but not limited to, oral contraceptives, intrauterine devices, and the rhythm method;
- a record of pertinent medical, reproductive, and social history;
- initial and annual breast, abdominal, and pelvic examinations, including Papanicolaou smear and determination of blood pressure;
- continued supervision by a qualified physician;
- provision of contraceptive supplies on a continuous basis;
- routine laboratory tests, i.e., hematocrit, urine or sugar and albumin, and a serologic test for syphilis.²¹

The *Guidelines* also refer to the educational and social services which must be provided by the project. These include:

- identification, contact, and recruitment of prospective patients;
- information and instruction to patients and prospective patients on the utilization of family planning services;
- assistance with clinic attendance (e.g., transportation, child care) if necessary, and
- follow-up supportive services to assist patients in securing continuing medical care.²²

The *Guidelines* recommend, with regard to employment and retraining of ancillary or paraprofessional staff, that:

each project must provide for a systematic plan for the training and career development of personnel at all levels. Special emphasis should be given to the initial and in-service training of ancillary personnel with the objective of providing job development . . .²³

In addition, individual projects must involve the community, and "members of the service population to be served should be employed whenever possible. This is a means of personalizing service and improving communications."²⁴

The Code of Federal Regulations requires that: the project must be coordinated with related services of the local health and welfare departments, hospitals and related voluntary agencies, and health projects supported by OEO. Where appropriate, there should be referral arrangements with local welfare departments for services to persons under the Aid to Families with Dependent Children Program.²⁵

The *Guidelines* state specifically that the following referral services should be included in the projects:

1. diagnostic and treatment services with referral as indicated for the infertile couples . . .
2. treatment and/or referral and follow-up of patients with complications or other suspected or diagnosed medical problems to suitable facilities . . .
3. referral and follow-up to appropriate counselling and social services when needed . . .²⁶

3. Eligibility for Services: The only eligibility criterion contained in the *Code of Federal Regulations* deals with income. It states that services must be available:

Only to persons who because of low-income or for other reasons beyond their control could not otherwise obtain services comparable to those provided under the project. However, if specific income standards are used, they must be applied flexibly, with due regard for total family needs in the particular case. Determinations of eligibility for services . . . shall be made by the project director or a member of the staff designated by him . . .²⁷

The *Guidelines* state further that the family planning services projects must:

Require no direct charge for service to the patient. Income standards shall not be used to exclude individuals from receiving services. (Grantees should seek reimbursement, however, from public or private health insurance if such coverage is available. A written agreement with the agency administering the medical assistance program is required to obtain reimbursement for beneficiaries of Title XIX of the Social Security Act.)²⁸

The *Code of Federal Regulations* further prohibits the refusal to serve patients on various grounds besides income. The regulations specify that services must be available:

Without any requirement for legal residence other than a requirement that the person or family to be served is currently residing in the project area; Upon referral from any source or upon the patient's own application; . . . without regard to race, religion, national origin, maternity [family size] or marital status . . .²⁹

The *Guidelines* add ". . . age" and ". . . sex" to the list of grounds which cannot be used to refuse service to patients.³⁰

4. Special Conditions: Prohibition of Coercion: Prohibitions against coercion, similar to those applicable to the Title V formula grant funds, are applicable to the family planning services project grants. The *Code of Federal Regulations* states:

Acceptance of services under the project must be voluntary, and individuals must not be subjected to any coercion to receive services or to employ or not to employ any particular method of family planning. Acceptance of family planning services shall not be a prerequisite to eligibility for or receipt of any other services . . .³¹

The *Guidelines* for applicants provide further protections against coercion. They state that the project must:

- Provide services without coercion. Services shall not be denied on the basis of refusal to participate in research or other activity.
- Insure freedom of choice of contraceptive methods so long as there are no medical contraindications to the method selected.³²

The standard requirements of Title V in regard to the "Observance of Religious Beliefs" are applicable to project grants. (See MCH Formula Grants, Special Conditions, above)

5. Federal Financial Support: The statute and the *Code of Federal Regulations* permit the state health agency, the health agency of any political subdivision of the state (with the consent of the state health agency) and any other public or nonprofit private agency, institution, or organization to apply for family planning services special project grants. The *Guidelines* stress, that "all applicants are advised to coordinate and cooperate with State and local public health agencies. DHEW's Regional Health Director reserves the right to forward applications to the State Health Officer for his information."³³

The required nonfederal share for special projects grants is 25 percent. This is established by the statute. The *Code of Federal Regulations* explains that funds may be derived from ". . . new State or local appropriations or other new grantee funds and existing funds and time of personnel used for on-going activities of the grantee agency which are made a part of the project."³⁴

The *Guidelines* add that ". . . income from private sources including health insurance and contributions and Federally derived funds as specifically allowed (e.g., DHUD Supplemental Model Cities funds) " may be used.³⁵

The *Code* prohibits use of "services or space donated to the project" or "grantee funds or services derived from other Federal funds . . . [unless specifically allowed] . . . or used for matching any other Federal grant," as the nonfederal contribution.³⁶

The *Guidelines* urge grantees to "seek reimbursement from public or private health insurance if such coverage is available. A written agreement with the

agency administering the medical assistance program is required to obtain reimbursement for beneficiaries of Title XIX of the Social Security Act.”³⁷

The *Guidelines* also state that “funds” derived from State programs under Titles IV–A and B and Title XIX of the Social Security Act [Aid to Families with Dependent Children, Child-Welfare Services, and Medical Assistance Programs], must be used to augment the activities of the family planning services project which is receiving grant support. When so used, they must be in addition to the sources of support specified above and not as a substitute for them.”³⁸

Details about the grant application process, lists of allowable expenditures, etc., may be found in the *Code* and the *Guidelines*.

6. Administration and Expenditures: Administration of the Title V program of special project grants for family planning services was delegated to the NCFPS-DHEW on October 23, 1969. On September 11, 1971, regulations were published which designated the NCFPS as the “lead agency” for the family planning activities of HSMHA, and the agency in charge of administration of “family planning project grant and contract activities.”³⁹

Project grant approval and general administration were delegated to the Regional Health Directors, who are assisted by the Regional Family Planning Directors and their full staff in these endeavors.⁴⁰

The total appropriation for family planning project grants under Title V was \$29.5 million in FY 1971 and \$27 million in FY 1972. The amount to be requested and made available for special projects is estimated and proposed by the Director of Maternal and Child Health Services of HSMHA-DHEW.⁴¹

Footnotes to “Title V, Social Security Act”

1. Title V, § 501.
2. Title V, § 512.

3. Title V, § 505 (a) (12) .
4. Title V, § 506 (e)
5. Title V, § 508 (a) (3) .
6. *Childrens Bureau Health Grants Manual*, Part 13–1.6 Pg. 8, Part II “D.”
7. *Ibid.*, Part II “C,” Page 8.
8. *Op. Cit. Childrens Bureau Health Grants Manual*, 13–1.6, Part II A.
9. *Ibid.*, 13–1.5 G.
10. *Ibid.*, 13–1.6 F.3.
11. *Ibid.*, 13–1.8.
12. Code of Federal Regulations (CFR) , § 200.20.
13. Title V, SSA, § 515.
14. *Ibid.*, § 503.
15. “Director’s Letter MCH”—70–2 May 12, 1970.
16. Hearing before the Subcommittee on Public Health and Welfare of the House Committee on Interstate and Foreign Commerce, 91st Congress, Second Session, August 3, 4, and 7, 1970, Page 93.
17. *Family Planning Services Project Grants of the National Center for Family Planning Services: Policies and Guidelines for Applicants*, DHEW–PHS–HSMHA, February 1971, Page 1.
18. *Ibid.*
19. *Op. Cit. CFR* § 208.8 (f) .
20. *Ibid.*, (g) (h) .
21. *Ibid.*, Page 3.
22. *Ibid.*, Page 4.
23. *Ibid.*, Page 4.
24. *Ibid.*, Page 6.
25. *Op. Cit. CFR* § 208.8 (c) .
26. *Op. Cit. Family Planning Services Project Grants*, Pages 3–4.
27. *Op. Cit. CFR* § 208.7 (f) .
28. *Op. Cit. Family Planning Services Project Grants*, Page 5.
29. *Op. Cit. CFR* § 208.7 (a) (b) (e) .
30. *Op. Cit. Family Planning Services Project Grants*, Page 5.
31. *Op. Cit. CFR* § 208.8 (b) .
32. *Op. Cit. Family Planning Services Project Grants*, Page 5.
33. *Ibid.*, Page 2.
34. *Op. Cit. CFR* § 208.5.
35. *Op. Cit. Family Planning Services Project Grants*, Page 2.
36. *Op. Cit. CFR* § 208.5.
37. *Op. Cit. Family Planning Services Project Grants*, Page 5.
38. *Ibid.*, Page 2.
39. 36 *Federal Register* No. 177, Saturday, Sept. 11, 1971, Page 18338.
40. 35 *Federal Register* No. 92, Tuesday, May 12, 1970, Pages 7387–7388.
41. *Op. Cit. “Director’s Letter” MCH*–70–2.

ECONOMIC OPPORTUNITY ACT, AS AMENDED — PART B OF THE ECONOMIC OPPORTUNITY ACT OF 1964

A. General Purposes and Provisions of the Law

The purpose of Title II—Urban and Rural Community Action Programs (CAPs)—as defined by the law, is “to stimulate a better focusing of all available local, state, private and Federal resources upon the goal of enabling low-income families, and low-income individuals of all ages, in rural and urban areas, to attain the skills, knowledge, and motivations and secure the opportunities needed for them to become self-sufficient.”¹

General rules to assist in achieving these purposes and for the operation of all Office of Economic Opportunity (OEO) programs administered by Community Action Agencies (CAAs) are found in a chapter of the *Code of Federal Regulations* (45 CFR IX) dealing with general OEO administration; the VISTA program; participation of the poor in CAPs; funding, policy, and evaluation of CAPs and the role of State Economic Opportunity Offices. The purposes of the CAPs have also been described as follows:

Community Action was a commitment to localism, the development and operation of programs at the local level, engaging a wide variety of local groups in the decision making process.²

1. Family Planning Provisions: Although some family planning programs were undertaken under Title II prior to 1967, specific authority for the provision of family planning services was added to the law in that year by amendments to Sections 221 and 222:

• Section 221 is the basic authority by which Community Action Agencies (CAAs) are provided with financial assistance for community action programs, known as Local Initiative Programs. The section (§ 221 (a)) lists the various activities which may be conducted, including “family planning, consistent with personal and family goals, religious, and moral convictions.”³

Another paragraph (§ 221 (b)) allows the Director of OEO to provide direct support for the activities listed, including family planning services, to “serve the needs of low-income families and individuals,” under special conditions, such as where there is no CAA or (with approval of the CAA), where it is determined that another agency would be most effective.⁴ In such instances, the Director of OEO

can enter into financial arrangements directly with public or private nonprofit agencies or organizations.

• Section 222 (a) establishes “Special Programs and Assistance,” known as Special Emphasis Programs. This section gives the Director of OEO a great deal of initiative in establishing certain special programs, among which are Project Headstart, the Follow-Through program, and the Comprehensive Health or Neighborhood Health Center Services program as well as the Family Planning program. This section states:

In order to stimulate actions to meet or deal with particularly critical needs or problems of the poor which are common to a number of communities, the Director may develop and carry on special programs under this section.⁵ ... Programs under this section shall include those described in the following paragraph:

... A ‘Family Planning’ program to provide assistance and services to low-income persons in the field of voluntary family planning including the provision of information, medical assistance, and supplies. The Director and the Secretary of HEW shall coordinate, and assure a full exchange of information concerning, family planning projects within their respective jurisdictions in order to meet the varying needs of different communities. The Secretary of HEW shall make the services of Public Health Service Officers available to the Director in carrying out this program.⁶

OEO also has the authority to support research and demonstration activities in the field of family planning subject to the General Research and Development provisions of the Economic Opportunity Act. These research authorities are the only ones in the law not governed by provisions concerning federal financial contributions:

... financial assistance extended to a community action agency or other agency pursuant to Sections 221 and 222 (a) ... shall not exceed 80 per centum of the approved costs of the assisted programs or activities. The Director may, however, approve assistance in excess of such percentages if he determines, in accordance with regulations establishing objective criteria, that such action is required in furtherance of the purposes of this title.⁷

Finally, the law prohibits coercion and guarantees individual freedom in the program:

(A) no individual will be provided with any information, medical supervision, or supplies which that individual indicates are inconsistent with his or her moral, philo-

sophical, or religious beliefs; and (B) no individual will be provided with any medical supervision or supplies unless he or she has voluntarily requested such medical supervision or supplies.

The use of family planning services assisted under this title shall not be a prerequisite to the receipt of services from or participation in any other programs under this Act.⁸

No regulations were published in the *Federal Register* to define the scope of family planning services and how they are to be administered. Such definitions are found only in guidelines, part of which are included in the OEO manual, *Community Action for Health: Family Planning*, last published in October 1967. This manual has been supplemented from time to time by OEO circulars which are not readily available to the public.

2. Services to be Provided: "Special Conditions" for family planning services were issued in an OEO circular and then incorporated in the OEO manual. These "Special Conditions" state that "the program must be under medical supervision sufficient to ensure that all practices conform to accepted medical standards."⁹ Chapter IV of the manual stresses that "... the medical components of a family planning program must be under the supervision of a physician with training and/or demonstrated competence in the relevant professional skills." Routine physical examinations and laboratory tests "auxiliary to the provision of medical contraceptives" are to be provided according to the determination of the medical supervisor of the program. Family planning projects should "provide access for all clients, directly or through referral to a broad range of available medical and other health services." Infertility services are specified in this context.¹⁰

The manual also states: "Nearly all successful projects emphasize the importance of case-finding and other outreach programs as well as the provision of transportation and necessary social services."¹¹ Under "Principles of Program Operation," the manual stresses consumer participation and details some of the ways through which it may be achieved:

... As in all community action projects, there should be a provision of participation in decision-making by the members of the groups and residents of the areas to be served by the family planning project. They should take part in decision-making in the many areas not requiring professional expertise: location of services, hours of service and so forth. They can function as an advisory group to the staff, helping them gauge how successfully they are responding to the needs (spoken and unspoken) of the people. They can serve as the mechanisms through which requests are made and complaints filed and they can provide follow-through on these requests and complaints.¹²

The manual also makes clear that OEO favors programs which make extensive use of paraprofessional

workers in a variety of clinic functions and community education programs. These paraprofessional workers "... should be given adequate training for their jobs by persons with appropriate expertise."¹³

3. Eligibility for Services: There are no federal eligibility criteria in relation to age, marital or parental status. The manual states that discrimination is prohibited against "any potential beneficiary on the grounds of race, color, national origin and religion," but goes on to say that "local agencies may, however, establish other criteria for eligibility for information, medical assistance and supplies."¹⁴ Such criteria must be specified in the grant application.

One 'special condition' (#9) states: "Project funds shall be used exclusively for providing assistance to low-income persons, or to residents of the area served by the community action programs."¹⁵ However, under "Criteria for Recipient Eligibility," the manual states:

Where a family planning program serves an area or neighborhood in which poverty is concentrated, all residents of the 'target area' will normally be considered to meet this test...¹⁶

The income eligibility tables which define low-income levels, under which most OEO programs must operate, are also supplemented from time to time by circulars not generally available to the public. The *Code of Federal Regulations* contains the following eligibility table published first by OEO in the *Federal Register* to become effective after October 4, 1969:¹⁷

§ 1060.2-3 OEO Income Poverty Guidelines, 1969.

Family size	Nonfarm family	Farm family
1.....	\$1,800	\$1,500
2.....	2,400	2,000
3.....	3,000	2,500
4.....	3,600	3,000
5.....	4,200	3,500
6.....	4,800	4,000
7.....	5,400	4,500
8.....	6,000	5,000
9.....	6,600	5,500
10.....	7,200	6,000
11.....	7,800	6,500
12.....	8,400	7,000
13.....	9,000	7,500

For families with more than 13 members, add \$600 for each additional member in a nonfarm family and \$500 for each additional member in a farm family.

However, the Director of OEO revised the income guidelines in the *OEO Instructions, No. 6004-1.b*, dated December 1, 1970. They appear in the *Federal Register* as part of a DHEW Public Health Service

**All States (Including the District of Columbia)
Except Alaska and Hawaii, 1970.**

Family size	Nonfarm family	Farm family
1.....	\$1,900	\$1,600
2.....	2,500	2,000
3.....	3,100	2,500
4.....	3,800	3,200
5.....	4,400	3,700

For families with more than five members, add \$600 for each additional member in a nonfarm family and \$500 for each additional member in a farm family.

4. Special Conditions: There are certain limitations placed on the use of funds under the OEO family planning program. Until May 18, 1971, there were prohibitions against the use of OEO funds for "... any surgical procedures intended to result in sterilization or abortion." On that date the agency announced through *OEO Instructions 6130-1* that grant funds could henceforth be used for sterilization procedures; the prohibition on abortion remains in effect.¹⁹ Further, project funds cannot be used to "announce or promote" family planning through the mass media, and there is a ceiling of \$20 per patient per year which can be spent for contraceptive devices or drugs.²⁰ In spite of the issuance of *OEO Instructions 6130-1*, guidelines for the implementation of sterilization procedures have not yet been issued.

In addition to specific eligibility requirements set by the local CAAs, and the specific federal prohibitions with regard to advertising and abortion, the manual states that the project must not be in conflict with state or local laws.

Any form of coercion or compulsion to "... induce persons to use the family planning services funded by an OEO grant" is prohibited.²¹ Every individual is to be provided services "... which are consistent with his or her personal beliefs and needs."²² The use of family planning services financed by an OEO grant cannot be a "... prerequisite to the receipt of services from or the participation in any other program financed under the Economic Opportunity Act."²³

5. Federal Financial Support: Guidelines for the conduct of OEO local initiative and special emphasis program family planning grants (Sec. 221 and 222 (a) (6)), state: "When there is a Community Action Agency in the community, proposed programs should be submitted to that agency for application to OEO."²⁴ They also stipulate that a CAA can operate a family planning program either directly or through a contractual arrangement with a dele-

gate agency. Contracts may be arranged with any public or private nonprofit agency for the development and implementation of family planning programs. Applications are submitted to the CAA and, when approved, forwarded to the OEO Regional Office for final review and approval. In such cases, the CAA in the community is the grantee, even though the project may be carried out under contract to a delegate agency.

Family planning activities funded under the research and development provisions (§ 222 (b)) operate under different rules than do the other programs. Under this authority, where working through the CAA is inexpedient, an independent agency may apply directly to the Director of OEO for separate funding.²⁵ The *Code of Federal Regulations* contains no specific provisions for the conduct of these projects. Administrative instructions are contained in a two-page summary prepared by the Division of Family Planning, April 1971, entitled, "Instructions for Preparing Funding Requests for Family Planning Projects." These instructions further specify that parts of the booklet *Applying for a CAP Grant*,²⁶ be used for such application together with other forms to be obtained from OEO headquarters. These instructions have not been printed in the *Federal Register* and were distributed only to a mailing list compiled by OEO.²⁷

The local share required for federal support under the OEO legislation and regulations was set at 20 percent on June 30, 1967. However, the Director has discretion to waive this requirement under certain conditions. For example, in the case of single purpose agencies, the regulations state:

The non-Federal share of an established single-purpose grantee in a community where there is also a CAA will be determined on the basis of the single-purpose grantee's own history. The same will be true for applicants for independent funding of new programs.²⁸

In addition, the *Code of Federal Regulations* provides a complete waiver for the *Emergency Food and Medical Services Programs*.²⁹

The guidelines set forth in the manual for family planning projects set the basic nonfederal share at 20 percent. They also state that "the requirement for nonfederal share may be met by cash or in-kind contributions."³⁰

It is not clear from the materials available what the local share requirements are under the research and development program.

6. Transfer of Programs to DHEW: On April 29, 1971, the Secretary of HEW and the Director of OEO signed a memorandum of understanding which sets forth a plan for the transfer of some OEO family planning projects to DHEW. Approximately 76 projects are listed as involved in the transfer. The stated effective date of transfer of each project is the

day after the end of its current or adjusted program year. The memorandum sets forth the proposed transfer date for each project.

In addition, the memorandum states general policies concerning the transfer and describes the criteria used for selection of projects to be transferred—such as, grant programs of \$1 million or more jointly funded by OEO and DHEW which have been in operation for at least two years, other jointly funded OEO–DHEW projects in certain geographic areas, and “mature” research and development projects.

Major posttransfer responsibilities are also stated; they include a guarantee that no project grant will be taken away from one grantee or delegate agency and given to another within a period of three years after the transfer date unless the Director of OEO gives his approval to DHEW for such action or the grantee or delegate agency agrees to same. Project operations can be taken away, however, within the three-year period in the case of a grant which is terminated for cause after reasonable notice and opportunity for a full and fair hearing as well as reasonable notice and opportunity to show cause prior to the refusal of continued assistance.³¹

Other posttransfer responsibilities include an agreement that no personnel will be discharged solely because of the transfer, and that DHEW will continue to require each transferred project to ensure the active, meaningful involvement of the low-income consumers of health services in implementing the program and in the organizational structure through:

1. The governing board of the grantee or delegate agency administering the transferred project being structured so that at least one-third of its members are low-income persons eligible to receive services from the project and at least one-half of its members are either low-income persons eligible to receive services or representatives of community groups such as social services organizations and labor or business organizations; or
2. A family planning council being established which acts as a policy advisory board to the administrative agency and is structured so that at least 51% of its members are low-income persons eligible to receive OEO health services. The neighborhood residents selected for the governing board and health council would be democratically selected and their terms normally would not exceed two years.³²

The activities in which the family planning council would be involved are also described.

DHEW also agreed to provide the necessary funding (approximately \$10 million) for these projects, thereby releasing funds in the OEO budget.

7. Administration and Expenditures: The family planning services activities of OEO are administered by the Director of the Family Planning Division of the Office of Health Affairs of OEO with the assist-

ance of OEO Regional Offices and CAAs. Presently, all OEO family planning activities operate under the authority of the law as amended last by the Economic Opportunity Amendments of 1969. These amendments extended the OEO programs for two years to June 30, 1971, and earmarked \$15–30 million for family planning services, depending upon total appropriations for OEO.

It has been proposed by the President and members of both Houses of Congress that the OEO program be extended for another two years. No change in federal share has been proposed. The proposed new authorities would extend the programs through June 30, 1973.

The FY 1971 appropriations for family planning programs under the Economic Opportunity Amendments was \$18.8 million. As this report was being completed (February, 1972), FY 1972 appropriations for OEO had not yet been passed.

Footnotes to “Economic Opportunity Act, As Amended”

1. Economic Opportunity Act, as amended, Title II [hereinafter cited as EOA], § 201 (a); 42 U.S.C. 2781.
2. *Economic Opportunity Amendments of 1969*, Senate Report 91–453, p. 14.
3. EOA, Part B, § 221 (a) (5); 42 U.S.C. 2808.
4. Ibid. Sec. 221 (b); 42 U.S.C. 2808.
5. Ibid. Sec. 222 (a); 42 U.S.C. 2809.
6. Ibid. Sec. 222 (a) (6); 42 U.S.C. 2809.
7. Ibid. Sec. 225 (c); 42 U.S.C. 2812.
8. Ibid. Sec. 244 (4); 42 U.S.C. 2836.
9. *Community Action for Health: Family Planning*, OEO, October 1967, pp. 11–12; “CAP FORM 29” (Rev. Aug. 68) GSA DC 6912299.
10. Ibid. pp. 16–17.
11. Ibid. “Scope of Service,” p. 17.
12. Ibid. “A. Community Relations,” pp. 15–16.
13. Ibid. “C. Staff,” p. 17.
14. Ibid. “D. Criteria for Recipient Eligibility—2. Other Eligibility Criteria,” p. 13.
15. Ibid., pp. 11–12; CAP FORM 29.
16. Ibid., p. 13 “D. Criteria for Recipient Eligibility—1. Income Criteria.”
17. 45 CFR X § 1060.2–4.
18. *Federal Register*, Vol. 36, No. 64—April 2, 1971, pp. 6115–6116. These income levels were further revised by OEO Instruction 6004–1c, November 19, 1971, and these instructions are included in the Supplement to this Report.
19. “OEO Instructions 6130–1,” also see CAP FORM 29 revised.
20. Op. Cit. CAP FORM 29 or see *Community Action for Health: Family Planning*, pp. 11–12.
21. Ibid.
22. Ibid.
23. EOA, as amended, § 244 (4) 42 U.S.C. 2836.
24. Op. Cit. *Community Action for Health: Family Planning*, p. 18.
25. EOA, as amended, § 222 (b) .
26. OEO Instruction 67 10–1, 1967.
27. Mailing is contained in “OEO Instruction 6000–1b,” Dec. 1, 1970, p. 1.
28. 45 CFR X § 1068.1 (b) (3) p. 404.
29. 45 CFR X § 1068.1 (b) (7) p. 405.
30. Op. Cit. *Community Action for Health: Family Planning*, p. 25.
31. *Congressional Record*, July 21, 1971, pp. E8027–E8030.
32. Ibid.

SERVICE PROGRAMS FOR FAMILIES AND CHILDREN — TITLE IV-A, SOCIAL SECURITY ACT, AS AMENDED

A. General Purposes and Provisions of the Law

The purpose of the Title IV-A service program is to “help maintain and strengthen family life” and to help individuals attain self-sufficiency through the provision of certain required and optional services which are mandated in the law. These include: family planning services, child care services, foster care services, services to prevent or reduce births out-of-wedlock, services linked to Work Incentive Program (WIN) enrollees and to employment objectives, and services related to health needs.¹

The law provides federal financial support to enable states to provide these services and also provides for the purchase of some services, including family planning services, “to the extent specified by the Secretary.” Since general medical care for public assistance recipients is normally expected to be provided through Title XIX, the *Code of Federal Regulations* specifically permits the use of Title IV-A funds for the purchase of medical care related to the services listed above. Therefore, if a state authorizes the purchase of services in its state plan for Title IV-A, the *Code* states that federal financial participation is available for those services which include “. . . medical and remedial care and services as part of family planning services.”² The *Code* goes on to authorize “. . . services furnished . . . by States or local agency staff . . . and volunteers, or . . . by purchase, contract, or other cooperative arrangements with public or private agencies or individuals, provided that such services are not available without cost from such sources.”³

The law also establishes certain general categories of eligibility for all Title IV-A services:

...any child or relative who is receiving aid under the plan, or to any other individual (living in the same home as such relative and child) whose needs are taken into account in making the determination [of financial assistance] . . .

...any child or relative who is applying for Aid to Families with Dependent Children or who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of such aid.⁴

The *Code of Federal Regulations* defines as eligible “families and children who are current applicants for financial assistance . . . former applicants or recipients . . . and are likely to become applicants or

recipients . . .” Those “likely to become” applicants or recipients are defined to include persons covered under state Medicaid plans, and those who:

...would be eligible if the earnings exemptions granted to recipients applied to them.

...are likely within 5 years to become recipients,

...are at or near dependency level including those in low-income neighborhoods and among other groups that might otherwise include more AFDC cases where services are provided on a group basis.⁵

The same section of the *Code* permits states to include in their plans, “all other families and children for information and referral services only.”

The *State Plan Guide*, issued by DHEW's Community Services Administration (CSA), requires that a state plan “. . . include specific identification of (1) the services to be provided (or purchased), (2) the families and children to whom the services will be available, (3) those services to be secured from other agencies without cost, and those to be purchased from other agencies.”⁶

States have the option to include only current recipients of AFDC or to include one or more of the three additional categories of persons—past recipients, current applicants, potential applicants and recipients—in their Title IV state plan for services. Most of the states do not cover all groups listed as eligible in the Guide, the regulations and the Statute.⁷

Finally, the law requires that whatever services are provided to a person under the plan, must be provided equally to all persons eligible under the plan throughout the state. This is known as the ‘Statewideness’ requirement which is mandated in the following language:

A State Plan for aid and services to needy families with children must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them . . .⁸

This requirement was included to enable and encourage states to develop services on a statewide basis as quickly as possible. However, it may have resulted in discouraging states from initiating certain services because resources were inadequate to establish services of the same quality immediately on a statewide basis. A DHEW Social and Rehabilitation Services (SRS) memorandum clarifies this point and

indicates that services can be initiated in selected areas if there is a "genuine commitment" to expand the program progressively:

The principle of statewideness does not arbitrarily require the concurrent initiation of services everywhere at precisely the same stroke of the clock... What it does require, however, is a genuine commitment by a state agency to provide services statewide as expeditiously as possible... For example, in the case of day care, the first stage of implementation might be a referral service to help individuals take advantage of existing resources.⁹

1. Family Planning Provisions: Family planning services are required for all "appropriate" persons receiving AFDC assistance and for other appropriate individuals specified in the law as mentioned above. The law also requires that the state plan, which must be submitted to DHEW as a prerequisite for federal aid, provide for "the development of a program for each appropriate relative and dependent child receiving aid under the plan, and each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination" of financial assistance with the objective of "... preventing or reducing the incidence of births out-of-wedlock and otherwise strengthening family life..."¹⁰

The law also requires that the state plan provide "for the implementation of such program by furnishing child-care services [and] ... in all appropriate cases family planning services..."¹¹

2. Services to be Provided: The law does not define family planning services. However, there are three sources of program directions emanating from SRS—the regulations which are published in the *Code of Federal Regulations* and have the strength of law, and two manuals which interpret these regulations for State administrators.

The *Code of Federal Regulations* requires that family planning services be "offered and provided to those individuals wishing such services." It defines family planning services as:

...specifically including medical contraceptive services (diagnosis, treatment, supplies, and follow-up), social services and educational services... Medical services must be provided in accordance with the standards of other state programs providing medical services for family planning (e.g., maternal and child health services).¹²

The *State Plan Guide* requires that State plans identify the family planning services offered and provided. However, it does not give as detailed a description of the medical components of family planning services as do the regulations.¹³

The SRS Title IV services manual also omits a detailed description of medical components. Where the regulations require that family planning services "be provided," the services manual requires only

that recipients "have access" to family planning services.¹⁴

The regulations set forth in the *Code* also require that clients be offered a "choice of method" and be provided with a "choice of source of service" through "various medical resources." Such "choice of source of service" may be provided through purchase of services from various agencies.¹⁵

The *Code of Federal Regulations* and the *State Plan Guide* require that the state plan, in describing the family planning services to be offered, contain assurances that "individuals will be assured choice of method and that arrangements have been made ... with varied medical resources so that individuals can be assured choice of source of service."¹⁶

The section of the services manual dealing with cooperative arrangements adds the qualifier "to the extent possible" with regard to giving eligible individuals the "opportunity to exercise choice with regard to the provider of source of the purchased services."¹⁷

The services manual also points out that the provision of family planning services, which is mandated, results in "immediate and greater demands upon the resources of the agency and of other agencies providing these services..."¹⁸ It recognizes that the demand for these services may exceed the available supply of free services when it states that "planning with agencies currently providing such services will assist those agencies to determine what, if any, services they can provide to persons of concern to the welfare agency, for whom referral is indicated, without cost or with purchase." The manual goes on to state: "When medical contraceptive services are not available from other programs, the State must provide or purchase them as service expenditures..."¹⁹ and adds:

The governing consideration that should apply in determining whether selected services are to be provided by the agency or secured from other sources is which will assure the most effective, most readily available, most usable and most economical service.²⁰

3. Special Conditions: Prohibition of Coercion: The law requires assurances from the state that no one may be forced into acceptance of such services. It requires that the state plan state:

...that the acceptance by such child, relative, or individual of family planning services provided under the plan shall be voluntary on the part of such child, relative, or individual and shall not be a prerequisite to eligibility for or the receipt of any other service or aid under the plan.²¹

4. Eligibility for Services: Beyond the general eligibility requirements discussed above (General Purposes and Provisions of the Law), the *Code* prohibits the refusal of services to patients on the basis of "marital status, age, or parenthood."²² However,

the services manual issued in 1969 states: "With respect to youths, voluntary consent includes parental consent if such is required by State law."²³

Among the various categories of clients who may be served, there are two groups which receive special mention in the law.

- The first group consists of those persons who would benefit from services "... preventing or reducing the incidence of births out-of-wedlock and otherwise strengthening family life." The *Code of Federal Regulations* sets the following program priorities:

... services must be extended progressively to all appropriate adults and youths, with initial priority for mothers who have had children born out-of-wedlock within the 2 preceding years or who are currently pregnant out-of-wedlock and for youths living in conditions immediately conducive to births out-of-wedlock. Services must be provided also to "fathers of such children."²⁴

The services manual states that "... the kinds of services that are specific to this objective include information and outreach activities, residential centers for comprehensive services for teenage girls who are pregnant or have a baby born out-of-wedlock, arrangements for medical services, educational programs regarding sex and personal living, counseling, planning for and training in child-care, maternity home services, establishing paternity, securing support and otherwise protecting the rights of out-of-wedlock children."²⁵

DHEW's first annual report on services to families under Title IV comments on the various approaches to serving these individuals:

There is no single approach to a social problem as complex as that of illegitimacy. A variety of methods and approaches must be tried if there is to be a reversal of the long-term upward trend in the extent of illegitimacy in the United States.

Since the enactment of the amendments, public welfare agencies have pursued a number of approaches aimed at reducing illegitimacy. One of the major new developments has already been discussed—family planning services. About half of all illegitimate births in the United States are to teenagers under the age of 20, and another third are to young women aged 20–24. Programs designed to reduce illegitimacy, therefore, must preeminently be addressed to teenagers and to youths just above this age level. Efforts to make family planning services available to teenagers have progressed but ... special problems are frequently encountered in reaching and serving minors.

The report singles out "parental consent"—as one of these "special problems."

By and large the services that have advanced most are addressed to the teenager who is already pregnant or who has had an illegitimate child. Usually there is less question of requiring parental consent to offer service to these girls and many of them gain access to social and medical family planning services by virtue of being known to health, welfare, and educational agencies ... Far more difficult of

attainment is the goal of 'primary prevention,' the effort to reach young people early enough to prevent even the first out-of-wedlock pregnancy.²⁶

Neither the law nor the regulations mention "parental consent." This requirement is introduced at the federal level for the first time in the services manual.

- The second group of individuals specifically mentioned in the law are those referred to the Department of Labor under the Work Incentive Program (WIN) for employment or training. (Title IV–C of the Social Security Act).

Under the law, the required services for WIN enrollees include, among others, child care, family planning, and other medical services related to health and employability. With regard to medical services the *Code* states:

All persons referred to the WIN program will be provided a prereferral medical examination to determine the individual's condition for participating in work and training activities, unless adequate information for this purpose is already available. States are urged to provide restorative medical services directly related to the participant's employability utilizing all available resources such as ... title XIX programs.²⁸

The Maternal and Child Health Service of DHEW has issued *Guidelines* to the Work Incentive Program which state:

If the potential enrollee has not already been informed by the welfare agency of the availability of family planning services, discussion of this resource, if appropriate for the individual, should be included in prereferral services. Pregnancy has been and is one of the most frequent causes of drop-outs in employability programs.²⁹

With regard to the prereferral medical examination, the *Department of Labor's Work Incentive Program Handbook* states:

The Department of Health, Education, and Welfare has established the policy of providing medical examinations for all enrollees, prior to enrollment. The local welfare agency will provide the examinations ... The WIN sponsor shall refer the enrollee to the welfare agency for medical treatment. The medical services available within the welfare agency vary by States. When the desired treatment is not available within it, the welfare agency shall utilize other community medical resources (local civic groups who pay for medical treatment for the poor, doctors who donate part of their time to such cases, etc.).³⁰

There is no mention of family planning services specified.

The first annual report on the Work Incentive Program issued by the Department of Labor in 1970 contains this statement about required services and prereferral medical examinations:

Though the program calls for medical examinations prior to referral, these are difficult to arrange and medical resources are lacking in many areas. In many projects, even where examinations are adequate, there are no provisions

for correcting the medical problems that are barriers to employment . . . One reason is that while the Federal Regulations urged States to make use of Title XIX funds, requirements for State matching have limited their use.³¹

The second annual report on the Work Incentive Program, issued by the Department of Labor in June 1971, indicates that four percent of all enrollees who terminated training and gave reason for such termination left because they were pregnant. Since the percentage is calculated in terms of all male and female terminations, it is difficult to ascertain what percentage of female terminations were due to pregnancy.

DHEW's second annual report on Title IV Services, issued in July, 1971, stated the following about medical services for WIN enrollees:

A major problem at the beginning of the program, which is still persistent although diminished, is the inadequate provision for medical care . . . follow-up medical care as a consequence of the medical examination is a problem that has become more severe. The Title XIX Medicaid program is a major resource in the States for the provision of medical services . . . Unfortunately, in a number of States, the program is not broad enough to cover certain common medical deficiencies that are discovered . . . Some States have recently reduced coverage in Medicaid, which will exacerbate the problem.³²

5. Federal Financial Support: The federal share for support of services under Title IV-A of the Social Security Act is 75 percent; the state must contribute 25 percent in matching funds.

The total amount of federal funds available for the Title IV-A service program is determined by the estimated total funding required by the States to furnish those specific services to those groups of persons indicated in their state plan. It is not limited by an authorization ceiling established by law.

6. Administration and Expenditures: The Title IV-A program for services to AFDC recipients (including WIN enrollees) and other appropriate persons is administered by the Community Services Administration of the Social and Rehabilitation Service of HEW (CSA/SRS) under regulations issued on February 26, 1971.³³

The Division of Child and Family Services of CSA/SRS "provides professional consultation and assistance to regional office staff and assists it in the guidance and leadership of State public welfare agencies and other public and voluntary agencies in development, extension and improvement of quality programs offering social and related service for children and families."³⁴

At the state level, the plans are administered by the individual state welfare departments; the Division of Child and Family Services of CSA/SRS assists the states in developing programs and formulates policies and guidelines for the national program of

services under Title IV-A and B of the Social Security Act.

The WIN program is administered by the Division of Self-Support Programs of the CSA/SRS (which develops and issues guidelines and program materials to assist the regional offices, states and localities in carrying out their responsibilities under the programs) and by the Manpower Administration of the Department of Labor.

A recent study conducted for DHEW on provision of family planning services under Title IV-A reported:

While the states are required to provide services to all appropriate AFDC recipients, only 10 states estimate that more than 20 percent of their eligible clients are receiving family planning help. (These 10 states were more likely than states with lower estimates to have based their evaluation on pure surmise.)³⁵

States have considerable difficulty in assessing levels of program efforts and in providing even rough estimates of expenditures for family planning. In FY 1970 only \$2.5 million could be identified for expenditures under both Title IV-A and Title XIX.

Most states have difficulty in identifying funds spent for medical family planning services, since these expenditures are frequently combined with other medical expenditures. Only 13 states made estimates for fiscal year 1969 and 12 states made projections for 1970 . . . Title XIX (Medicaid) was used to a greater extent than Title IV-A (AFDC), particularly for drugs and devices . . . total projections for FY 1970 . . . [expenditures by States for family planning services and drugs and devices under both Title IV and Title XIX] . . . are only a little more than \$2.5 million—compared to \$2 million in FY 1969, and only 11% could be allocated to medical services. Only three of the States which responded to this question in the survey (California, Illinois and Pennsylvania) said that they planned substantial family planning expenditures.³⁶

DHEW'S second annual report on Title IV services does not provide any estimate of spending levels under the program.

Footnotes to "Title IV-A, Social Security Act"

1. 45 *CFR* II § 220.15-220.24.
2. *Ibid.* § 222.88.
3. *Ibid.* § 222.87.
4. Social Security Act, as amended, Title IV-A, § 403 (a) (3) (A) (i-ii).
5. *Op. Cit.* *CFR* § 220.52.
6. *State Plan Guide—Services to Families and Children—Title IV-A and B, Social Security Act*, Community Services Administration of the U.S. Department of Health, Education, and Welfare, 1970, § 3.1 (b) p. 15.
7. See State profiles.
8. Social Security Act, as amended, Title IV-A, § 402 (a) (1).
9. Letter from Commissioner, Community Services Administration of the Social and Rehabilitation Service to the State Public Welfare Agencies, May 8, 1970.
10. Social Security Act, as amended, Sec. 402 (a) (15) (A) (ii).
11. *Ibid.*
12. *Op. Cit.* *CFR* § 220.21.
13. *Op. Cit.* *State Plan Guide* § 3.7, p. 19.

14. *Guides on Federal Regulations Governing Service Programs for Families and Children*; Title IV, Parts A and B, Social Security Act, Community Services Administration, Social and Rehabilitation Service, DHEW, 1971, § 220.21, pp. 27-28.
15. Op. Cit. *CFR* § 220.21.
16. Op. Cit. *State Plan Guide*, pp. 19-20.
17. Op. Cit. *Guides on Federal Regulations* § 220.8, p. 15.
18. Ibid. § 220.8, p. 14.
19. Ibid. § 220.21, p. 28.
20. Ibid. § 220.8, p. 14.
21. Op. Cit. Social Security Act, as amended, § 402(a) (15) (C).
22. Op. Cit. *CFR* § 220.21.
23. Op. Cit. *Guides on Federal Regulations*, § 220.21, p. 28. Also note the U.S. House of Representatives Conference Report No. 1533 on the Revenue and Expenditure Control Act of 1968, June 10, 1968: "The conference committee does not believe that the provisions of the existing law which are involved require any state to take action contrary to state statute and expects the Department of Health, Education and Welfare to so interpret and administer the provision referred to in the Senate Amendment."
24. Op. Cit. *CFR* § 220.20.
25. Op. Cit. *Guides on Federal Regulations Governing Service Programs* § 220.20, p. 27.
26. *First Annual Report of DHEW to the Congress on Services to Families Receiving Aid to Families with Dependent Children under Title IV of the Social Security Act*, July 1970, pp. 48-49, Community Services Administration SRS/HEW.
27. Op. Cit. Social Security Act, as amended, § 402 (a) (19) (A).
28. Op. Cit. *CFR* § 220.35 (a) (ii).
29. *Guidelines—Work Incentive Program Children's Bureau/SRS/DHEW—CB-11-1969* July, 1969, § 44.4, "Family Planning."
30. *Work Incentive Program Handbook*, U.S. Department of Labor, Manpower Administration—TN13-68, § 418 and 525 7/25/68.
31. *First Annual Report of the Department of Labor to the Congress on Training and Employment under Title IV of the Social Security Act*, U.S. Department of Labor, June 1970, p. 35.
32. *Second Annual Report of the U.S. Department of Health, Education and Welfare to the Congress on Services to Families Receiving Aid to Families with Dependent Children under Title IV of the Social Security Act*, CSA/SRS/DHEW, July, 1971, p. 35.
33. *Federal Register*, Vol. 36, No. 39, Friday, February 26, 1971, pp. 3537-3538.
34. Ibid., p. 3538.
35. J. Goldman and L. Kogan, "Public Welfare and Family Planning," *Family Planning Perspectives*, Vol. 3, No. 4, Oct. 1971, p. 19.
36. Ibid.

MEDICAID — TITLE XIX, SOCIAL SECURITY ACT, AS AMENDED

A. General Purposes and Provisions of the Law

Two 1965 amendments to the Social Security Act (PL 89-97), greatly expanded the role of the federal government in general health care financing;

- Title XVIII, also known as Medicare, provides medical and hospital insurance for individuals over the age of 65;
- Title XIX, generally known as Medicaid, assumes the cost of medical care for certain impoverished individuals, the majority of whom are under the age of 65.

The purpose of Title XIX is stated as:

enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services; and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care...¹

Title XIX became effective on January 1, 1966, and states gradually submitted plans for participation under Title XIX and the phasing out of their former medical assistance programs (if any). As of January 1, 1970, all states but Alaska and Arizona had federally approved Medicaid plans; the four U.S. territories were similarly covered.

It was the objective of Title XIX to encourage the establishment by each state of a unified system of medical assistance to all who are unable to pay for their own medical care. As a first step, the states were expected to provide, with federal assistance, standard benefits to all individuals who receive cash assistance under any one of the federally aided "categorical" public assistance programs: Aid to Families with Dependent Children (AFDC), Aid to the Permanently and Totally Disabled (APTD), Aid to the Blind (AB) and Old Age Assistance (OAA) or Aid to the Aged, Blind or Disabled (AABD), an administrative alternative to the last three listed programs. The long-term goal was to encourage states to work towards liberalizing eligibility standards and expanding the content of care with a view to providing, by 1975, comprehensive services to virtually all individuals who meet the state's individual financial eligibility standards. However, mounting medical expenditures and concerns over the quality

of care purchased with Title XIX funds have led more to the curtailment of Medicaid services than their expansion. The target date for the provision of comprehensive services has been postponed from 1975 to 1977 (by the Social Security Amendments of 1969). At the same time, the states were relieved until 1971 of the requirement that they show progress toward meeting the long-range goal. It is now generally acknowledged that Medicaid has proved itself to be both expensive and ineffective in meeting the medical needs of the poor, and national attention has shifted to the consideration of alternative systems of health care financing such as National Health Insurance.

The following basic services were required of all state programs by the 1965 Amendments:

- (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
- (2) outpatient hospital services;
- (3) other laboratory and x-ray services;
- (4) skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for individuals age 21 or older;
- (5) physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere.²

Further amendments in 1967 added additional service requirements for all state Medicaid programs:

- Effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in the regulations of the Secretary;
- and with respect to calendar quarters beginning after June 30, 1970, home health care services for any individual who, under the State plan, is entitled to skilled nursing home services.³
- Transportation to and from medical care and services was added as a requirement by regulation of the Secretary in the summer of 1968, to be effective July 1, 1969, later postponed to July 1, 1970.⁴

1. Family Planning Provisions: Altogether the law lists a total of 15 subcategories of health services which are approved as part of the medical assistance to be provided under Title XIX. Three of the basic services enumerated above—"outpatient hospital services," "other laboratory and x-ray services," and

"physicians' services"—are relevant to family planning services; there are five additional categories of approved services which could encompass the provision of the essential components of a family planning service. These are:

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

(9) clinic services. . . .

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select . . .

(13) other diagnostic, screening, preventive, and rehabilitative services . . .

(15) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary . . .⁵

If the definition of family planning services adopted by the Social and Rehabilitation Service (SRS) ("Family planning services including drugs, supplies, and devices, when such services are under the supervision of a physician."⁶) is to be used, it would appear that Medicaid has the potential to finance at least the central medical care component of family planning services (e.g., medical examination and prescription, cancer detection and other laboratory tests and the necessary contraceptive drugs), for persons who are eligible for Medicaid.

Although family planning is not specifically mentioned in the statute, the regulations published in the *Federal Register* do mention family planning services specifically as part of "any other medical care recognized under State law," listing: transportation, family planning services (including drugs, supplies and devices), where such services are under the supervision of a physician, services of Christian Science Nurses and other nursing and emergency services.⁷

The *Handbook of Public Assistance Administration* provides the same definition of family planning services as the regulations: "family planning services, including drugs, supplies and devices, where such services are under the supervision of a physician."⁸ The *Handbook* also states that the states must first assist officials and recipients in identifying and securing needed services. The states are then expected to extend their services to "case finding to identify the particular families, children and adults who are in need of social services related to their health and medical needs" and, finally, to show:

there is an annual progression in initiating and extending Statewide the following social services to or on behalf of families and individuals described . . . to assure that these services are furnished to or secured for all families and individuals in need of them by July 1975 . . . *Social services related to family planning* for families and individuals.⁹

In view of the postponement of the various deadlines for extension of services mentioned earlier, it is uncertain what progress has been made in meeting these objectives.

2. Special Conditions: Prohibition of Coercion: Throughout the *Handbook* there are sections which repeat the requirements that in any state plan which includes family planning services "there will be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals can choose in accordance with the dictates of their consciences."¹⁰

3. Eligibility for Services: Title XIX of the law requires that all programs include in their coverage the *categorically needy*, who are those persons receiving financial aid under the four categorical public assistance programs enumerated above (AFDC, APTD, AB, OAA).

The programs *must* also include the *categorically related needy*, who are those persons who *would* qualify for the four categorical public assistance programs except for failure to meet state residence requirements or other state-imposed eligibility conditions. Everyone younger than 21 years of age who, except for a state age or school attendance requirement, would be eligible under one of the public assistance categories if the state eligibility requirements were as broad as the federal legislation permitted *may* be included in the categorically related needy group.

The programs *may* include the *categorically related medically needy*, who are those persons who *could* meet the social or physical characteristics and the income level to qualify for a categorical public assistance program (AFDC, APTD, AB or OAA) but do not receive welfare payments, and those persons who have the social or physical characteristics to qualify for a categorical public assistance program except for having income and resources large enough to cover daily living expenses, but not adequate to pay for medical care. *Federal cost-sharing is available only for services rendered to the categorically needy, the categorically related needy and the categorically related medically needy.*¹¹

Finally, the programs *may* also include the *non-categorically related medically needy*. Medical services, if provided to this group, are paid for entirely by the state since no federal sharing of medical costs is available for individuals in this category.¹² The noncategorical group may consist of persons who are receiving or are eligible for General Assistance under a statewide welfare program, or persons who do not qualify for categorical public assistance programs and who have income and resources large enough to cover daily living expenses, but not adequate to pay for medical care. The tables below classify the 52

Medicaid programs now in existence according to their coverage of the population in need.

In the first group (Table 10) are the 25 states which provide medical assistance only to those individuals who are in the *categorically needy* or the *categorically related needy* groups. They are persons who are either receiving welfare (cash) assistance, or who have the same social or physical characteristics as welfare recipients (blind, aged, or members of families with dependent children—that is, usually, families in which at least one parent is absent or incapacitated). In addition, their income is below the state's welfare eligibility standards. In the *categorically needy* groups, the basic caseload is made up of individuals who are recipients of federally-aided financial assistance.

Table 10. States Which Provide Medical Assistance Only to the Categorically Needy or Categorically Related Needy, by State

Alabama	Missouri
Arkansas	Montana
Colorado	Nevada
Delaware	New Jersey
Florida	New Mexico
Georgia	Ohio
Idaho	Oregon
Indiana	South Carolina
Iowa	South Dakota
Louisiana	Tennessee
Maine	Texas
Mississippi	West Virginia
	Wyoming

Source: *Characteristics of State Medical Assistance Programs Under Title XIX* (see footnote 4).

In the second group (Table 11) are the 28 states and jurisdictions which provide medical assistance, with federal financial assistance, to the *categorically related medically needy*, in addition to the *categorically needy*. These are individuals who: a) meet the social and physical conditions of eligibility of the *categorically needy* groups; b) have income which is above the levels established for the receipt of welfare (cash) assistance but insufficient to meet the costs of needed medical care; but c) whose income and resources are above welfare levels but are at or below an income level projected for basic maintenance needs as determined by the state in accordance with certain federal statutory requirements. Table 11 provides the annual income levels established by the states for these individuals.

4. Coverage of Family Planning Services: Since the scale of the services provided and the eligibility for the program are largely determined by the states, it has been and is difficult to get accurate informa-

tion on the operation of medical programs. The task has been made even more difficult by frequent legislative and administrative changes often prompted by "crisis" financial and political situations at the local and state levels. The most recent, and most complete, effort to gather comprehensive information as to state policies is embodied in the study of the Social and Rehabilitation Service (SRS), *Characteristics of State Medical Assistance Programs under Title XIX of the Social Security Act* (See footnote 4). According to the preface, "data, all as of January 1970, come from federally approved state agency responses to a special questionnaire. In every instance the text has been reviewed and approved by the appropriate state agency." This document, therefore, appears more authoritative than other SRS compilations based on state plan submissions which are generally incomplete or out-of-date. Under *Section B. Medical and Remedial Care and Services*, a description is included of services pro-

Table 11. Annual Income Levels for the Medically Needy in 28 Title XIX Plans in Operation on January 1, 1970, for a Family of Four, by State and Federal Jurisdiction

State or Jurisdiction	Annual Income (for family of 4)
California	\$3,600
Connecticut	4,400
Delaware*	3,300
District of Columbia	3,560
Guam	3,000
Hawaii	3,480
Illinois	3,600
Kansas	3,000
Kentucky	3,420
Maryland	3,100
Massachusetts	4,176
Michigan	3,540
Minnesota	3,516
Nebraska	3,000
New Hampshire	4,056
New York	5,000
North Carolina	2,800
North Dakota	3,000
Oklahoma	2,600
Pennsylvania	4,000
Puerto Rico	2,600
Rhode Island	4,300
Utah	2,700
Vermont	3,420
Virgin Islands	3,630
Virginia	3,000
Washington	4,260
Wisconsin	3,100

* Broader coverage terminated as of May 14, 1970.

Source: *Characteristics of State Medical Assistance Programs* (see footnote 4).

vided by each state under 21 categories. Three of these services (Nos. 10, 13 and 15) are particularly relevant to the provision of family planning services. They are "Clinic Services (other than hospital)," "Prescribed Drugs," and "Family Planning Services."¹⁸

Of the 25 states which cover welfare recipients only, or welfare recipients and some or all individuals with similar characteristics, nine (Alabama, Arkansas, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Texas and Wyoming) specify that they do *not* cover family planning services. Since specialized clinics have been a major source of family planning services, a state's coverage of clinic services may be an important indication of the availability of services in that state. Of the 16 states which report that they do cover family planning services, two (Colorado and Montana) do not pay for any clinic services; two (Florida and Missouri) provide them only to the indigent population over 65; one (Ohio) authorizes only the clinics operated by the health department (under other programs); Oregon indicates that prior authorization is required from county welfare departments for 'elective' procedures. Therefore only 10 or 11 states in this group appear able to finance family planning through both private physicians and clinics. Whether they are, in fact, doing so is difficult to ascertain since reimbursement arrangements are usually arrived at locally and facility-by-facility.

In addition to the foregoing, there were reported in the study administrative restrictions which may further limit the availability of services. These restrictions can be seen in Table 12. For example, Colorado reports family planning services as "provided, consisting of physician's services, drug, supplies and devices." However, the description of the family planning services "provided" goes on to indicate that "physician's services [are] limited to medical visit(s) necessary to determine medications or devices to be used." Although family planning services are reported as "provided . . . No limitations" in Florida, the entry states that "prior authorization by local office [is] required for physician's services." As noted earlier, neither of these states authorizes payments for clinic services. Barring complications or unusual circumstances, Nevada's requirement that prior authorization by the state office be obtained for "physician's visits in excess of three per month, for drug prescriptions, supplies and devices exceeding cost of \$15," may not be a serious impediment. However, Ohio's policy to reimburse physicians "on basis of 60 percent of usual, customary and reasonable fees" and to pay only "nominal fees" to "Planned Parenthood agencies for drugs and supplies" is not likely to encourage the wide availability of services.

Of the 27 states which, at the time of this study, covered not only the categorically but also the medically needy, none specifically exclude family planning services. However, most of the limitations encountered above are repeated, although perhaps less frequently and less stringently. For example, clinic services are *totally* excluded in five states (Kentucky, Maryland, North Carolina, Rhode Island and Utah). In Nebraska, clinic services are covered, but excluded are "payments to family planning organizations for consultation or for materials dispensed." In California clinic services are authorized only following, and within 90 days of, inpatient hospital care. In North Dakota, prior authorization has to be obtained for prescription drugs, including oral contraceptives, from the county welfare board. No refills are allowed and the authorization is valid for 30 days only. In New Hampshire, the only services allowed are those authorized for Medicare. In Puerto Rico, Tennessee, the Virgin Islands and Virginia, Medicaid eligibles are referred for all clinic services to public health clinics. In Vermont and Wisconsin, the only clinic services approved are those for the provision of mental health services to the medically indigent. Therefore, when it comes to family planning services, only 12 states offer, even in principle, a choice of clinics and private physicians' services through their Medicaid programs. As has been noted earlier, the extent to which this potential is utilized cannot be determined with any accuracy since reimbursement arrangements are highly dependent upon local conditions. Four states, however, specifically mention clinic services in relation to family planning: *Connecticut* states that services "may be provided by physician or certified family planning clinic"; *Michigan* authorizes payment for medical services, drugs, etc. "provided by qualified family planning clinics, M.D., D.O., and pharmacy"; *Illinois* approves payments for family planning services to "physicians and organized facilities"; *New York* reimburses on the basis of ". . . applicable fee schedules (i.e., schedules for physicians, clinics, drugs and sick room supplies)." *North Dakota* reimburses a variety of facilities but requires that a separate authorization be obtained "for services of each provider utilized (e.g., physician, clinic, pharmacist)." (See Table 13.)

Most of the 48 states and four jurisdictions with Title XIX programs report that they provide drugs under their state Medicaid plans. There are numerous restrictions attached to such provision of drugs. These are detailed in Table 14. In some cases it is not clear whether these restrictions are applicable to contraceptive supplies. As can be seen from Table 14 only seven states report providing no drugs (Arkansas, Idaho, Mississippi, Oklahoma, South Dakota, Texas and Wyoming); of these, five also do not

Table 12.

Provision of Medical Service in State Medicaid Programs, by State*

State	Clinic	MDs†	Family Planning	State	Clinic	MDs†	Family Planning
Ala.			"Not provided."	Miss.			"Not provided."
Ark.			"Not provided."	Mo.	No§	Yes	"Provided."
Calif.	No‡	Yes	"Provided, but not as a separately identified service."	Mont.	No	Yes	"Provided. Upon recommendation of family physician."
Colo.	No	Yes	"Provided . . . Physician's services limited to medical visit(s) necessary to determine medications or devices to be used."	Nebr.	Yes	Yes	"Provided. No payments to family planning organizations for consultation on materials provided."
Conn.	Yes	Yes	"Provided . . . by physician or certified family planning clinic."	Nev.	Yes	Yes	"Provided. Prior authorization by state office required for physician's visits in excess of 3 per month."
Del.	Yes	Yes	"Provided."	N.H.	No‡‡	Yes	"Provided."
D.C.	Yes	Yes	"Provided."	N.J.	Yes	Yes	"Provided."
Fla.	No§	Yes	"Prior authorization by local office required for physicians' services."	N. Mex.	Yes	Yes	"Provided."
Ga.			"Not provided."	N.Y.	Yes	Yes	"Provided. Payments to physicians, clinics . . ."
Guam	Yes**	Yes	"Provided."	N.C.	No	Yes	"Provided."
Hawaii	Yes	Yes	"Provided. Including sterilization, fertility tests and correction of infertility."	N. Dak.	Yes	Yes	"Provided. Separate authorization by county welfare board required for each provider utilized (e.g., physicians, clinic . . .)"
Idaho	No	Yes	"Provided."	Ohio	No§§	Yes	"Provided. Reimbursement of physicians on basis of 60% of usual, customary and reasonable fees."
Ill.	Yes	Yes	"Provided [by] [p]hysicians and organized facilities."	Okla.			"Not provided."
Ind.	Yes	Yes	"Provided."	Oreg.	Yes*†	Yes	"Provided."
Iowa	Yes	Yes	"Provided."	Pa.	Yes	Yes	"Provided" for both categorically needy and medically needy.
Kans.	Yes	Yes	"Provided."	P. R.			Not provided under Medicaid.
Ky.	No	Yes	"Provided."	R.I.	No	Yes	"Provided."
La.			"Not provided."	S. C.			
Maine	Yes	Yes	"Provided."	S. Dak.	Yes	Yes	"Provided. Legend drugs only. (Other services through clinics of Department of Public Health.)"
Md.	No	Yes	"Provided."	Tenn.	No*‡	Yes	"Provided."
Mass.	Yes	Yes	"Provided."	Texas			"Not provided."
Mich.	No	Yes	"Provided for categorically needy only." Services provided by a "qualified family planning clinic, M.D., . . ."	Utah	No	Yes	"Provided."
Minn.	Yes††	Yes	"Provided. County agency may establish prior authorization requirements subject to state agency approval (none in effect as of 1/1/70)."	Vt.	No*§	Yes	"Provided."

Table 12. (continued) Provision of Medical Service in State Medicaid Programs, by State*

State	Clinic	MWs†	Family Planning	State	Clinic	MDs†	Family Planning
V. I.			Not provided under Medicaid.	Wash.	No	Yes	"Provided. Under supervision of a physician."
Va.	No†*	Yes	"Provided. Payment made only to providers which have entered into a participation agreement with state agency."	W. Va.	Yes	Yes	"Provided. Under the direction of a physician."
				Wis.	No*§	Yes	"Provided."
				Wyo.			"Not provided."

Source: SRS, *Characteristics of State Medical Assistance Programs under Title XIX of the Social Security Act*, DHEW, msa-ta No. 971, GPO, 1971, "B. Medical and Remedial Care," ".10 Clinic Services (other than hospital)," and ".15 Family Planning Service."

* With special emphasis on provisions relevant to family planning.

† Physicians' services are mandated under the law.

‡ Limited to 90 days, following hospitalization.

§ Limited to individuals over 65.

** When available.

†† County welfare agency may establish prior authorization requirements. Had not done so 1/1/70.

‡‡ Limited to clinics approved for Medicaid.

§§ Limited to services provided in public health clinics.

*† Prior authorization is required from county welfare department for "elective" procedures.

*‡ Limited to persons age 65 or older.

*§ Limited to mental health service.

†* Limited to services provided in public health and general medical clinics.

Table 13. Basis of Reimbursement for Medicaid Services, by State

1. *Variable, according to provider*

California
Delaware
Iowa
Minnesota
Missouri
Nevada
New Hampshire
New Jersey
North Dakota
Virginia

New York
Oregon
Pennsylvania
Rhode Island
Utah
Washington
Michigan
Montana
Nebraska
South Dakota
Vermont

West Virginia "up to fee guide maximum allowances."
Wisconsin "not in excess of maximum established by Medical Section of State Agency."

2. *Usual, customary and/or reasonable charges*

Colorado
Delaware
Guam
Hawaii
Idaho
Illinois
Indiana
Kansas
Kentucky

4. *Other*

Maine "reimbursement to physicians on the basis of usual and customary charges; to hospital and clinic on the basis of reasonable cost."

North Carolina "reimbursement to institutions on basis of reasonable cost . . . to practitioner on basis of usual, customary and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of January 1, 1969)."

Ohio "reimbursement of physicians on basis of 60% of usual, customary and reasonable fees."

Tennessee "reimbursement for 'legend drugs' only . . . other services available through clinics of Department of Health."

3. *Fee schedule*

Connecticut "Based on reasonable charge."
Florida
Maryland
Massachusetts "when appropriate, reasonable charges otherwise."
New Mexico

Note: Puerto Rico and the Virgin Islands do not provide any family planning services under Medicaid. Medicaid eligible patients are expected to utilize public health clinics when and where available. Another nine states report that they do not provide family planning services under Title XIX. They are: Alabama, Arkansas, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Texas and Wyoming. Alaska and Arizona do not have Medicaid plans.

Table 14.

Provision of Drugs in State Medicaid Programs, by State*

(Alabama)	"Legend and non legend" drugs.	Michigan	"Provided for categorically needy only" except for hospitalized medically needy. "Legend and non legend" drugs. Family planning "drugs, supplies and devices" provided.
(Arkansas)	Not provided.	Minnesota	"Legend and non legend" drugs. "Limit of 30 day supply per prescription except that 100 day supply allowed for chronic illness." Family planning "drugs, supplies and devices" are provided.
California	"Unlimited for categorically needy." Drugs are available to the medically needy only 90 days following discharge from an inpatient institution. Family planning "drugs, supplies and appliances" are provided.	(Mississippi)	Not provided.
Colorado	"Limited to legend drugs insulin and such medications and devices as are prescribed in family medications planning."	Missouri	"Limited to legend drugs . . . Restricted to original prescription and two refills, each of which may not exceed a 30 day supply except in extenuating circumstances, when a 90 day supply may be permitted . . . Family planning "drugs listed in drug formulary."
Connecticut	"Legend and non legend" drugs. Family planning "drugs, supplies and devices" are provided.	Montana	"Legend and non legend" drugs.
Delaware	"Legend" drugs. Family planning "drugs, supplies and devices" when "under supervision of a physician."	Nebraska	"Legend and non legend" drugs. Family planning "drugs, supplies and devices" are provided. "No payment to family planning organizations."
District of Columbia	"Legend and non legend" drugs. Family planning materials "limited to items listed in drug formulary."	Nevada	"Legend and non legend" drugs. Family planning "drugs, supplies and devices, when services are under the supervision of a physician."
Florida	"legend" drugs.	New Hampshire	"Legend and non legend" drugs. "Prior authorization required for [family planning] non legend drugs, supplies and devices."
(Georgia)	"According to State Medical Assistance Drug List."	New Jersey	"Legend and non legend" drugs. Limit of 60 days supply per prescription, with not more than two refills in a 6-month period; except for oral contraceptives, for which a 6-month supply may be prescribed initially, with two refills in a 9-month period."
Guam	"Legend and non legend" drugs.	New Mexico	"Legend drugs and insulin."
Hawaii	"Legend and non legend" drugs. "Refills not permitted except for contraceptive drugs for three cycles."	New York	"Legend and non legend" drugs. Family planning "drugs, supplies and devices" are provided.
Idaho	Not provided.	North Carolina	"Legend drugs and insulin."
Illinois	"Legend and non legend" drugs. "Prior authorization required for drugs not in formulary . . . Prescriptions limited to original and two refills."	North Dakota	"Legend and non legend" drugs. "Limited to original prescriptions (no refills) . . . Authorization by county welfare board required (issued for not more than 30 day period." Family planning "drugs, supplies and devices" are provided. "Separate authorization from county welfare board required for each provider (e.g., . . . pharmacist)."
Indiana	No limitations.	Ohio	"Legend and non legend" drugs. Family planning "drugs, supplies and devices" are provided.
Iowa	"Legend drugs and insulin . . . Prescriptions limited to 30 day supply except for maintenance drugs which may be prescribed in package quantities up to 100 day supply . . . No refills: new prescription required on each occasion." Family planning "drugs, supplies, and devices" are provided.	(Oklahoma)	Not provided.
Kansas	"Legend drugs and certain non legend drugs used for treatment of specified physical conditions." Family planning "drugs, supplies and devices" are provided.	Oregon	"All items on Basic Drug List." Prior authorization needed for "Exception Drugs . . . Under direction of physician; including drugs, supplies and devices."
Kentucky	"Legend drugs, limited to items on Medical Assistance Generic Drug List and with restrictions on unit amount of prescription." Family planning "prescription drugs" are provided. "Supplies and devices are not provided."	Pennsylvania	"Legend and non legend [drugs] listed in State Drug Formulary . . . Provided for categorically needy only . . . Maximum of 45 day supply per prescription (except, 80 day supply of anovulatory drugs) . . . Drugs, supplies and devices provided for categorically needy person only."
(Louisiana)	"Limited to life saving and essential drugs."		
Maine	"Legend drugs only . . . Maintenance drugs limited to 90 day supply with refills ordered by physicians." Family planning "drugs, supplies and devices" are provided. "No limitations, but services must be rendered under the supervision of a physician."		
Maryland	"Legend and non legend" drugs. Family planning "drugs, supplies and devices" are provided.		
Massachusetts	"Legend and non legend" drugs. Family planning "drugs, supplies and devices" are provided. "Must be on recommendation of physician."		

Table 14. (Continued). Provision of Drugs in State Medicaid Programs, by State*

(Puerto Rico)† "Legend and non legend" drugs. "Limited to drugs dispensed to patients through pharmacies of publicly operated hospitals, health centers and similar health facilities."

Rhode Island "Legend and non legend" drugs. "No payment for drugs dispensed by physician . . . Original prescription not to exceed 30 day supply of any drug . . . Refills (not to exceed 3 within 90 day period after date of original prescription was filled) allowed for certain drugs used for continuous treatment of chronic conditions." Family planning "devices, supplies, and appliances" are provided. "Prior written authorization by state office for items not covered by state Drug Formulary."

(South Carolina) "Limited to drugs and medicine essential to saving or (for persons receiving maintenance drugs) prolongation of life and to those drugs that will tend to limit the need for hospitalization."

South Dakota Not provided (as reported in B.11. However, B.15 states that "drugs, supplies and devices [are provided] when such services are under the supervision of a physician."

Tennessee "Legend drugs and insulin . . . Maximum of 2 refills per prescription, obtained within 90 days of original prescription . . . Original prescription not to exceed 30 days." Family planning "legend drugs only."

(Texas) Not provided.

Utah "Legend and non legend" drugs. Family planning "must be on a physician's prescription."

Vermont "Legend and non legend" drugs.

(Virgin Islands)† "Limited to services provided by Health Departments and professional staff."

Virginia "Legend (including insulin and oral contraceptives) and non legend drugs within the therapeutic classes . . . and family planning supplies."

Washington "Legend and non legend drugs, exclusive of common household drugs which can be purchased without a prescription." Family planning "drugs, supplies and devices" are provided. Services must be "under supervision of a physician."

West Virginia "All legend drugs, with exception of a few non-essential categories; plus certain non legend drugs." Family planning "under direction of a physician. Including drugs, supplies and devices."

Wisconsin "Legend and non legend" drugs. "For medically needy persons non legend drugs limited to insulin . . . Limit of 34 days supply on one prescription." Family planning "drugs, supplies, and devices" are provided to categorically needy. For medically needy persons, only drugs are provided.

(Wyoming) Not provided.

Source: SRS, *Characteristics of State Medical Assistance Programs under Title XIX of the Social Security Act*, DHEW, msa-la No. 971, GPO, 1971, "B. Medical and Remedial Care," ".13 Prescribed Drugs" and ".15 Family Planning Services."

* With special reference to contraceptive drugs and devices.

† Reports providing family planning services although services are *not* provided through Medicaid.

The states listed in parentheses are those which report that they do not provide family planning services

provide family planning services (Arkansas, Mississippi, Oklahoma, Texas and Wyoming). Two other states (Louisiana and South Carolina) provide drugs only for "life saving or essential" conditions, or in cases where they "will tend to limit the need for hospitalization"; neither program provides family planning services. As noted previously, Puerto Rico and the Virgin Islands do not provide any family planning services (physicians, drugs, supplies or devices) under their Medicaid programs; Medicaid-eligible patients are expected to utilize public health clinics (to the extent of their availability). Nebraska does cover drugs generally but specifically excludes "payments to family planning organizations for consultation or for materials dispensed."

In the other 38 states and two jurisdictions, contraceptive drugs, supplies and devices *may* be included in the general drug coverage. However, several states specify particular restrictions. Kentucky covers contraceptive drugs but "no supplies or devices." In Missouri, drugs listed in the Formulary are covered but "birth control devices [are] not included." In this case, supplies are not mentioned. Nonprescription supplies may be excluded by the

requirement that family planning drugs be provided "at the prescription of a physician" or "upon the recommendation of a physician" (such provisions echo the federal regulations which state that family planning services must be under the "supervision of a physician").¹⁴

Four states in which Medicaid covers both the *categorically needy* and the *medically needy*, report in the study that the family planning services provided vary among each group of Medicaid eligibles. California restricts the provision of drugs to the *categorically needy* (i.e., welfare recipients, except for hospital patients within 90 days of release). Michigan reports providing family planning services to the *categorically needy* only. Pennsylvania covers physicians' family planning services for all Medicaid eligibles, but limits coverage of drugs, supplies and devices to welfare recipients. Wisconsin provides physicians' services and drugs to all, but limits devices and supplies to the *categorically needy*.

Beyond these limitations, there are numerous other restrictions (also detailed in Table 14). Generally, these restrictions fall into two categories: As can be seen in the table, 12 states report providing

legend drugs only, or drugs listed in an official Formulary or other listing. In all these cases, it is not certain that contraceptive drugs are included, or that an appropriate range of products is provided. The extent to which devices or nonprescription supplies are included is unclear.

Thirteen states have restrictions of one kind or another on the length of time or other conditions under which an original prescription may be refilled. For example, in Iowa prescriptions are "limited to 30-day supply except for maintenance drugs which may be prescribed in package quantities up to 100 day supply"; a new prescription is required for each refill. In Missouri, provision is "restricted to original prescription and two refills, each of which may not exceed a 30-day supply except in extenuating circumstances, when a 90-day supply may be permitted"; in Rhode Island "original prescription [is] not to exceed 30-day supply of any drug, [with] refills (not to exceed three within 90-day period after date when original prescription was filled) allowed for certain drugs used for continuous treatment of chronic conditions." Tennessee, which covers only legend drugs under its family planning Medicaid program, has a "maximum of two refills per prescription, obtained within 90 days of original prescription." The original prescription may not exceed 30 days.

These types of restrictions, if applicable to family planning drugs and supplies, make difficult the routine prescription of contraceptive drugs in accordance with current medical practice norms, since they require repeated visits to the physician, clinic or pharmacist. From the information available, it is not possible to determine whether they are in fact applied to family planning. It may be noted, however, that the five states which do specify that they cover contraceptive drugs clearly exempt these drugs from the types of restrictions mentioned above. *Colorado*, which is "limited to legend drugs, insulin", expands coverage to "such medications and devices as are prescribed in family planning medications." *Virginia* mentions "family planning supplies" among the nonlegend drugs which are approved. *Hawaii* exempts contraceptive drugs from its ban on refills: "Refills not permitted except for contraceptive drugs for three cycles." *New Jersey* has a limit of a 60-day supply of drugs per prescription, with not more than two refills in a six-month period "except for oral contraceptives, for which a six-month supply may be prescribed initially, with two refills in a nine-month period." *Pennsylvania* extends its 45-day limit to 80 days for "anovulatory drugs."

5. Federal Cost Sharing and Administration: The federal government contributes toward the states' Medicaid expenditures at three different rates. For

the costs of administration, the federal matching rate is 50 percent for all states. For the cost of medical personnel, "federal financial participation at 75 percent is available for the compensation of skilled professional medical personnel, and staff directly supporting such personnel, of the state agency or any other public agency, in the administration of the medical assistance program at the State and local level, and for their training and educational leave with respect to Title XIX."¹⁵ For medical care costs the federal share is established by a formula written into the law. The federal contribution in this case is inversely proportional to the per capita income of the state and ranges from 50 to 83 percent. (See Table 15.)

For the *medically needy* population, the states must establish financial eligibility standards which are subject to federal policies and guidelines. They must determine a level of income which will be "protected for maintenance"¹⁶ (e.g., not considered available to meet the costs of medical care), and a maximum on personal resources which may be retained by the applicant for medical assistance (See Table II.)

The Title XIX program is administered by two subagencies of SRS, the Medical Services Administration and the Assistance Payments Administration. The latter formulates "policies, standards and methods relating to proper and efficient administration of State and local cash assistance programs."¹⁷ The Medical Services Administration "assists States in planning for and in extending the scope, content and quality of the programs, . . . [and] develops modifications and innovations in the administration of Title XIX programs . . . [and] develops reimbursement standards" for providers of medical care.¹⁸

At the state level, one state agency must be designated as the Medicaid agency. However, certain functions are delegated to other public agencies and to insurance carriers.

6. Family Planning Service Levels under Medicaid: It has been extremely difficult to obtain information on the number of medically indigent individuals receiving family planning services under Medicaid and, as a corollary, to determine the level of expenditures for these services. This information is not easily secured, by state, or for the nation as a whole, since Medicaid is not an organized program for the delivery of services, but a fiscal arrangement for the reimbursement of varied medical services provided under very varied conditions by a very large number of providers. Two studies have attempted to gather information as to Medicaid expenditures for family planning. The first was conducted by the Center for Family Planning Program Development (CFPPD)

Table 15. Percent of Federal Contribution for Medical Assistance, by State, Promulgated for the Period of 7/1/70-6/30/71

Alabama	78.43
Alaska*	50.00
Arizona*	64.15
Arkansas	79.42
California	50.00
Colorado	57.61
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	60.67
Georgia	69.67
Guam	50.00
Hawaii	50.83
Idaho	71.56
Illinois	50.00
Indiana	55.05
Iowa	58.07
Kansas	59.06
Kentucky	73.49
Louisiana	73.49
Maine	69.43
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	56.82
Mississippi	83.00
Missouri	59.53
Montana	67.16
Nebraska	58.48
Nevada	50.00
New Hampshire	59.36
New Jersey	50.00
New Mexico	72.63
New York	50.00
North Carolina	72.84
North Dakota	71.28
Ohio	53.65
Oklahoma	69.02
Oregon	57.39
Pennsylvania	55.45
Puerto Rico	50.00
Rhode Island	50.26
South Carolina	78.00
South Dakota	69.69
Tennessee	74.35
Texas	65.18
Utah	69.88
Vermont	64.71
Virgin Islands	50.00
Virginia	64.03
Washington	50.00
West Virginia	76.97
Wisconsin	56.28
Wyoming	62.73

* Not applicable; no Title XIX program.

in 1969;¹⁹ the second was carried out by the City University of New York in 1970 under contract to DHEW.²⁰

In the CFPPD study, the 43 States and territories with approved Title XIX plans were surveyed to determine eligibility requirements, services offered and approved providers. They were also asked whether the number of patients served (in the fiscal year) could be determined and, if so, how. If this number could not be determined, they were asked whether an estimate could be provided instead. Thirty-three of the respondents indicated that they could neither determine nor estimate the number of patients who received family planning services during that year. Two jurisdictions (Puerto Rico and Georgia) were positive that no family planning services had been made available through the program. Three states (Kentucky, Oregon and Rhode Island) provided total estimates; Illinois and Iowa provided partial estimates. Program directors in Kansas and Pennsylvania indicated that an estimate could be made, but either had not been made or was not available at the time. In the nine states which could provide some estimates it was not clear whether both medical services and drugs had been paid for under the program. The total number of patients identified as receiving some service was less than 25,000. This is not to say, of course, that no services were provided in the states which could not provide estimates.

The City University study was designed to assess the implementation of family planning services under Title IV-A of the Social Security Act. Since the states can utilize both Title IV-A and Title XIX funds to finance family planning services to welfare recipients and other groups, the survey included a number of questions aimed at elucidating the extent to which states made use of either mechanism to meet the mandate of the law (see Title IV-A profile above). The City University of New York study, like the CFPPD study, found that the states had great difficulty in identifying funds expended for medical family planning services. Only 13 states provided estimates for FY 1969 expenditures, and 12 projected their expenditures for FY 1970. Title IV-A appeared little used as a financing mechanism for the purchase of family planning services; less than \$109,000 in Title IV-A funds could be identified as family planning expenditures among the 13 states in FY 1969. Projections for FY 1970, through both Title XIX and Title IV-A amounted to only \$2,543,898.²¹ Again, states which provided either no estimates or partial estimates cannot be assumed to provide no services but, there is no way to measure the level of their program efforts. In view of the intricate set of restrictions mentioned earlier in this section, a high service level and a correspondingly substantial level of expenditures, appear unlikely.

Footnotes to "Medicaid"

1. Social Security Act, as amended, Title XIX, § 1901.
2. Ibid. § 1905 (a) (vi) (1) - (5) .
3. *Characteristics of State Medical Assistance Programs under Title XIX of the Social Security Act*, U.S. Department of Health, Education and Welfare (DHEW-SRS (MSA-pa 49-71)) . Introduction p. ix.
4. Ibid.
5. Op. Cit. Social Security Act. § 1905 (a) (vi) (6) (9) (12) (13) (15) .
6. 45 CFR II-Social and Rehabilitation Service (Assistance Programs) , DHEW, § 249.10 (b) (15 (ii)) .
7. Ibid. § 249.10 (b) (15) .
8. *Handbook of Public Assistance Administration, Supplement D Medical Assistance Programs Under Title XIX of the Social Security Act*, U.S. DHEW/SRS/MSA, 1967, Part D-5141 "Definitions" p. 9 (15., b.) .
9. Ibid. Part D-6200 "Social Services" pp. 1-4.
10. Ibid. Part D-6220 p. 2; Appendix C, p. 8 item 7.
11. Op. Cit. *Characteristics of the State Medical Assistance Programs under Title XIX*, pp. viii-ix, xi.
12. Ibid. p. xi.
13. Ibid. pp. xiii-xv.
14. Op. Cit. 45 CFR II, § 249.10 (b) (15) (ii) .
15. Op. Cit. Social Security Act, § 1903 (a) .
16. Op. Cit. *Characteristics of State Medical Assistance Programs under Title XIX*, p. xii.
17. *Federal Register*, Vol. 34, No. 17, January 25, 1969, p. 1283.
18. *Federal Register*, Vol. 35, No. 52, March 17, 1970, p. 4661.
19. J. I. Rosoff, *Family Planning, Medicaid and the Private Physician*, CFPPD Publication No. 9, Planned Parenthood-World Population, New York 1969.
20. J. Goldman and L. S. Kogan, "Public Welfare and Family Planning," *Family Planning Perspectives*, Vol. 3, No. 4, Oct. 1971, p. 19.
21. Ibid. p. 21, derived from Table 11.

THE FEDERAL UNIFORMED SERVICES

A. General Medical Care Provisions for Active and Retired Members of the Uniformed Services and Their Dependents

The federal government has always assumed the responsibility for providing medical care to active duty members of the uniformed services. These consist of: the Army, the Navy, the Marine Corps and the Air Force, under the jurisdiction of the Department of Defense; the Coast Guard, under the jurisdiction of the Department of Transportation; the Commissioned Corps of the Public Health Service, under the jurisdiction of the Department of Health, Education and Welfare; and the Commissioned Corps of the National Oceanic and Atmospheric Administration (formerly the Environmental Science Services Administration), under the jurisdiction of the Department of Commerce.

The statutory authority for the provision of medical care to active duty members does not specifically mention family planning services. However, as there is specific authority for the provision of such services to retired members and the dependents (i.e., spouses, children, etc.) of both active duty and retired members, such services may reasonably be assumed to be inherent in the basic medical care authorized for active duty members of the uniformed services. In general, retired members of the uniformed services are entitled to the same medical care as active duty members, subject to the availability of space and facilities and the capabilities of the medical staff. A retired member is a former member who is entitled to retirement pay as a result of specified service in a uniformed service.

The statutory authority for the provision of medical care to retired members and dependents of active duty or retired members of all the uniformed services is found in Chapter 55, Title X of the United States Code. Public Law 89-614, the Military Medical Benefits Amendments of 1966, authorized additional improved medical benefits programs for dependents, as well as expanded medical care to include hospitalization, outpatient care, the treatment of medical and surgical conditions, drugs and physical examinations, and other formerly restricted medical services. While family planning services are not specifically mentioned in these amendments, the authorization for such services is assumed to be inherent, as evidenced by the inclusion of family planning

services in the regulations set forth in the *Federal Register* for April 8, 1971 regarding the Uniformed Services Health Benefits Program. These regulations were issued by the Department of the Army which has the responsibility for publishing regulations for all uniformed services concerning the Uniformed Services Health Benefits Program.

In regard to the administration of the Uniformed Services Health Benefits Program the regulations state:

The Secretary of Defense with jurisdiction over the Army, Navy, Air Force, Marine Corps, and the Coast Guard (when operating as a service of the Navy), and the Secretary of Health, Education, and Welfare with jurisdiction over the Public Health Service and for medical care purposes over the Environmental Science Services Administration and the Coast Guard (when not operating as a service of the Navy) are responsible for overall policy guidance for the implementation of the Uniformed Services Health Benefits Program. The Secretaries of the military departments and the Administrator, Health Services and Mental Health Administration, Public Health Service, are jointly responsible for implementation of the Uniformed Services Health Benefits Program authorized by the Secretaries of Defense and Health, Education and Welfare.¹

1. Family Planning Coverage: In a section which lists the various health benefits which may be provided to dependents in uniformed services facilities, the April 1971 regulations state in part: "Family planning services and supplies, including counseling and guidance... will be provided in accordance with sound medical practice to any dependent upon request."² The inclusion of sterilization and abortion under the general rubric of "family planning services" is made explicit by the provisions of another section which directs that a "nonavailability statement" is to be issued authorizing the individual to seek care through civilian facilities which will be paid for by the appropriate uniformed service:

when a dependent requests a therapeutic abortion or surgical procedure to produce sterilization and the medical facility commander determines that such procedure(s) is not medically indicated but that other competent medical authority might reasonably reach a contrary conclusion.³

In regard to authorized medical benefits for dependents and retired members under the Civilian

Health and Medical Program of the Uniformed Services (CHAMPUS), the regulations list:

family planning services including counseling and guidance. This includes premarital counseling, diagnostic tests, and drugs and devices obtainable only by prescription. Also includes surgical procedures to produce sterilization provided such procedures are consistent with the medical and legal standards of practice in the applicable jurisdiction.⁴

The regulations make no distinction between minor and adult dependents in regard to medical services authorized, either in uniformed services or civilian facilities. While the April 1971 Uniformed Services Health Benefits Program regulations specifically authorize the provision of family planning services to include sterilization, it should be noted that the *Code of Federal Regulations*, revised as of January 1, 1971, contains a part titled, "Medical Care for Dependents of Members of the Uniformed Services," which makes no mention of family planning services and restricts sterilization procedures to those which are medically indicated.⁵ These *Code of Federal Regulations* provisions were first published in 1962, also under the authority of Chapter 55, Title X of the United States Code. They do not reflect any of the expanded medical care benefits authorized by the Military Medical Benefits Amendments of 1966 and thus appear to be obsolete, although they have not yet been removed from the *Code of Federal Regulations*.

2. Fee Schedules: In general, when medical care is not available to retired members and dependents at uniformed services medical facilities, the CHAMPUS program authorizes the payment of medical benefits for any procedure and type of care furnished on an inpatient or outpatient basis by civilian sources, so long as such care is not specifically excluded by law. However, there is a published fee schedule which sets forth the patient's share of the cost for authorized services. For example, the patient share for outpatient benefits under CHAMPUS for dependents of active duty members is the first \$50 of expenses incurred by a patient each fiscal year (not to exceed \$100 per family), plus 20 percent of reasonable charges after deductible has been paid; and for inpatient care it is the first \$25 or \$1.75 per day, whichever amount is greater.⁶ For care in uniformed services facilities dependents of both active duty and retired members pay \$1.75 per day for inpatient care, and there is no charge for outpatient care.

B. Directives on Family Planning for the Military Services

In addition to the above cited regulations each of the military services, Army, Navy (to include Marine Corps) and Air Force, has also issued internal directives setting forth family planning policy. In

summary, a comparison of the Departments of the Army, Navy and Air Force family planning services policies indicates the following:

- In the three military services, "family planning services" are defined so as to include birth control or contraceptive services, sterilization, and abortion.
- Birth control services are authorized for active duty and retired members of the military services and their dependents.
- There are no stated restrictions on the provision of birth control services to minors.
- All family planning services are conditioned upon the availability of space and facilities and the capability of the medical staff at military installations.
- Sterilization procedures are authorized for active duty and retired members of the military services and their dependents.
- There is no requirement for concurring medical opinion or consultation in regard to a sterilization procedure.
- Medical personnel are not required to perform or participate in any surgical procedures that violate their moral, religious or professional principles. Such objections are considered as a lack of capability to provide care, and therefore, the patient can be transferred to another military medical facility, if appropriate or issued a "nonavailability statement" which would allow care under the CHAMPUS program.
- The written consent of the patient, and spouse if married, is required prior to surgical sterilization. The Department of the Air Force Regulation requires that patients considering sterilization be given a complete explanation of the advantages and disadvantages of the procedure and that the couple fully understand the expected results and that they request the procedure without reservation.
- In the case of sterilization procedures for minors, the written consent of the parent(s) or legal guardian is required. The Department of the Army provides greater detail in its regulation to the effect that sterilization procedures will not be performed on "normal unmarried minors" and that such procedures may be performed for "medical indications of mental defectiveness" with parental or guardian consent. The regulation does not make explicit whether married minors may obtain sterilizations. The Air Force regulation of July 1971 which authorizes sterilization procedures at Air Force medical facilities in accordance with "sound medical practices" states: "Neither State laws nor local practices will be a factor in making these determinations." This policy is not mentioned in the pertinent regulations of the Army and the Navy, perhaps because it was not felt

to be necessary in view of the general exclusion of military activities from state laws.

- Outside the United States, basic policies with respect to sterilization procedures are determined on a country-by-country basis, based upon local laws and mores and applicable status of forces agreements.

Until April 1971, abortions could be performed at military medical facilities without regard to state law. This was consistent with general military medical practice. However, in April 1971, the President made an exception to that military medical practice policy and directed that "... the policy on abortions at American military bases in the United States be made to correspond with the laws of the states where those bases are located. If the laws in a particular state restrict abortion, the rules at the military base hospitals are to correspond to that law." The internal directives of each military service reflect this Presidential policy.^{6a}

The family planning services programs for the military departments are under the supervision of the Surgeons General of the Army, Navy (to include the Marine Corps) and Air Force. No current estimate of expenditures for family planning services by the military departments is available. However, for Fiscal Year 1970, the *Special Analyses—Budget of the United States* lists the estimated obligation for family planning services by the Department of Defense at \$4.8 million. Such estimated obligations have not appeared in any subsequent *Special Analyses*.

The directives cited above are readily available to members of the military community, and are discussed in detail below.

1. Department of the Army: The Department of the Army's policies regarding family planning services and sterilizations to eligible individuals are stated in a series of messages issued between 1966 and 1971 to major Army commands. These policy messages were prepared by the Surgeon General of the Department of the Army and, although distributed in message form only, they establish policy in the same manner as a more formal published Army regulation.

Basically, these messages state that family planning services can include counseling, prescription of contraceptive medication and devices and the distribution of appropriate literature; and are authorized for eligible personnel "to the extent that professional capabilities and facilities permit and in conformity with the principles of sound medical practice as have always been applied within the military medical community."⁷

These messages further recommend that the development of a family planning program be established within the Ob-Gyn clinics at Army Medical facilities if possible.

In regard to sterilizations, Department of the Army policy is as follows:

Surgical sterilizations may be performed in Army medical facilities subject to the availability of space and facilities and the capabilities of the medical staff. Written consent will be obtained from the patient, and if married, from the patient's spouse prior to the procedure. If performed for medical indications or mental defectiveness in a minor, written consent will also be obtained from the patient's parents or legal guardian. Sterilization procedures will not be performed on normal unmarried minors. Additional consultant opinion is not required prior to performing a surgical sterilization procedure, except where medically indicated. Sterilization of females will be performed or supervised only by competent obstetrician-gynecologists. Sterilization of males will only be performed by physicians competent in the technique of transscrotal vasectomy.⁸

It would appear from the above that, in regard to eligibility for family planning services, no distinction is made between minor and adult dependents but that sterilizations for "normal unmarried minors" are prohibited and those for "medical indications or mental defectiveness" require the written consent of parent(s) or guardian. It is implied, but not altogether clear, that sterilization for married "normal" minors may be authorized.

The Army policy messages further indicate that medical personnel are not required to perform or participate in any surgical procedures that violate their moral, religious or professional principles. Such objections are considered as a lack of capability to provide care, and the patient may, therefore, be transferred to another military hospital, if appropriate, or issued a "nonavailability statement" which would allow care under the CHAMPUS program.⁹

2. Department of the Navy: The Department of the Navy's policies for active and retired members of the uniformed services and their eligible dependents, is set forth in a May 1971 Instruction from the Secretary of the Navy to "All Ships and Stations."

This Instruction states: "Family Planning Services' may include (1) the prescription and provision of pharmaceutical preparations, including oral hormonal contraceptives, and mechanical devices, (2) surgical sterilization, (3) abortion, and (4) counseling [and that] All services shall be rendered in conformity with the principles of accepted medical practice, and subject to the availability of space, facilities, and capability of the staff."¹⁰ The Navy Instruction continues:

Physicians and other medical personnel who consider the performance of such procedures morally or ethically wrong shall not be required to perform them. Where space and facilities are not available or the capability does not exist for performance of sterilization or abortion procedures at local medical facilities, the hospital shall arrange for transfer to another uniformed service medical facility or procurement of such services in a local civilian hospital, with a staff possessing the capability and willingness to so perform. In the case of an active-duty member receiving treatment in a civilian hospital, the cost thereof shall be

paid from funds of the sending naval hospital. Eligible dependents under such circumstances shall be issued certificates of nonavailability so they may have the procedure performed under CHAMPUS. Outside the United States major Navy overseas commanders shall determine on a country-by-country basis policies with respect to pregnancy terminations and surgical sterilization procedures, based on such considerations as pertinent mores, the applicable laws of the nations concerned, and applicable status of forces agreements.¹¹

In regard to surgical sterilization, this Instruction holds that the decision for sterilization is "a matter solely between the physician and patient . . ." and "no concurring medical opinions are necessary unless [sterilization is] medically indicated." Prior to performance of the sterilization procedure, written consent must be obtained from the patient and from the patient's spouse, if married. In the case of a dependent minor, written consent must be obtained from the parents, sponsor, or legal guardian.¹²

The Instruction further requires that only a physician competent in transscrotal vasectomy can perform male sterilizations and only a "competent" obstetrician-gynecologist can "perform or supervise" female sterilizations.

Except as set forth above in regard to sterilization procedures, no distinction is made between minor and adult dependents.

3. Department of the Air Force: The Department of the Air Force's basic policy for eligible service families is set forth in a December 1966 Policy Letter which was sent to major Air Force commands. This Policy Letter states:

Family planning services as provided at Air Force facilities will include (1) the prescription and provision of oral hormonal contraceptives, other pharmaceutical preparations and mechanical devices, (2) surgical procedures, and (3) counseling in contraceptive techniques. Where local capabilities permit, family planning services will be made available, upon request, to all individuals authorized care in uniformed military medical facilities.¹³

The term "surgical procedures" as used above means sterilizations and therapeutic abortions.¹⁴ Air Force policy in regard to both sterilization and abortion is contained in a separate Air Force Regulation.

No distinction is made between minor and adult dependents in this Air Force Policy Letter.

Current Air Force policy guidelines for "sexual sterilization" are contained in a July 1971 Air Force Regulation. This Regulation defines "sexual sterilization" as "a procedure performed solely or primarily for rendering a male or female incapable of procreation . . ." ¹⁵ and states:

Sterilization procedures may be performed in Air Force medical facilities in accordance with sound medical practice subject only to the availability of space and facilities and the capabilities of the medical staff. Neither state laws nor local medical practices will be a factor in making

these determinations. If the facility is not capable of performing the procedure, a patient may be transferred to another Air Force hospital . . . or be issued a . . . "Nonavailability Statement-Dependents Medical Care Program." The attending physician's moral, professional, or religious reluctance to perform sterilizations constitutes a lack of capability just as would lack of space or resources. Major overseas commanders will, on a country-by-country basis within the geographical area of their responsibility, determine whether these policies will be implemented for a particular country. Where medical facilities capable of providing these services are also operated by the other military departments, coordinated service policies should be implemented to insure uniformity of the treatment. . . . The major overseas commander should consider status of forces agreements, the applicability and effect of local laws and customs, and other relevant factors such as the categories of personnel which will be eligible for such services. The possible impact on US/host country relations should also be considered.¹⁶

Unless medically indicated, the Air Force has no requirement for concurring medical opinion or consultation for sterilization procedures. However, this Regulation does require that:

patients contemplating sterilization must receive a complete explanation of the expected results, the possibilities of failure, and the irreversible nature of the procedures. The patient and spouse (or parents as applicable) shall submit in writing a request and consent for the procedure . . . acknowledging that they understand its purpose and the expected results, and that they request the procedures without reservation.¹⁷

C. Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration and the Coast Guard

1. General Medical Provisions: Under the Uniformed Services Health Benefits Program, the Administrator, Health Services and Mental Health Administration, Department of Health, Education, and Welfare (HSMHA/DHEW) is responsible for the implementation of the medical care program for dependents and retired officers of the Public Health Service (PHS) DHEW, and the National Oceanic and Atmospheric Administration, Department of Commerce; as well as dependents and retired members of the Coast Guard, when the Coast Guard is not operating as a service of the Navy. The President has the authority to assign the Coast Guard to the Department of the Navy.

Medical care authorized under the Uniformed Services Health Benefits Program can be provided to the above-mentioned individuals at PHS medical facilities, other uniformed services medical facilities (Army, Navy, or Air Force) or civilian facilities under the CHAMPUS program, as appropriate.

2. Family Planning Provisions: With regard to the PHS regulations governing the provision of medical care to eligible PHS, National Oceanic and Atmos-

pheric Administration, and Coast Guard active duty and retired members and their dependents, the *Code of Federal Regulations* does not mention family planning services specifically. However, the *Federal Health Programs Service Operations Manual* of HSMHA does outline policy and procedures for providing family planning services and for the performance of surgical procedures for sterilization and abortion, in regard to all eligible beneficiaries of the Uniformed Services Health Benefits Program. This *Manual*, which is available at all PHS facilities, is updated as needed by Transmittal Letter from the Director, Federal Health Programs Service (FHPS), HSMHA.

The last updating of policies and procedures with regard to family planning services, sterilization, and abortion was issued April 20, 1971, through FHPS Operations Transmittal Letter No. 27. This letter states that family planning has been established as a priority program of DHEW, and it also refers to the Deputy Assistant Secretary for Population and Family Planning, an office which no longer exists but has been replaced by statute with the Office of Population Affairs headed by the Deputy Assistant Secretary for Population Affairs. The letter defines family planning services to include, "... one or more of the following: (1) the prescription and provision of pharmaceutical preparations, including oral contraceptives and mechanical devices, (2) surgical sterilization, (3) abortion, and (4) counseling."¹⁸

In regard to abortion, this letter adopted the previously mentioned Presidential policy which was directed at military medical facilities. It states: "Although the doctrine of Federal supremacy provides that state and local laws shall not be binding on Federal offices and employees acting within the scope of their office . . . it is Presidential policy that the performance of abortion procedures at federal medical facilities be made to correspond with the laws of the states where those facilities are located."¹⁸

3. Eligibility for Services: The letter sets forth the following eligibility requirements: "... all eligible Service [PHS] beneficiaries, including those of the Uniformed Services Health Benefits Program, subject to the availability of space, facilities, and the capability of the staff."¹⁹

4. Special Considerations: The letter states that medical personnel are not required to participate in surgical procedures which violate their personal beliefs:

Physicians and other attending personnel who consider the performance of any family planning service morally or ethically wrong shall not be required to perform or assist in the performance of them. In these circumstances

good medical practice requires only that the physician or other attending personnel withdraw from the case so long as the withdrawal is consistent with good medical practice.²⁰

With regard to sterilization the April 1971 Transmittal Letter states,

The decision for surgical sterilization is a matter between the physician and patient. This procedure shall require the decision of the operating surgeon only, and no concurring medical opinions are necessary unless medically indicated because of known or suspected complications. However, written consent shall be obtained from the patient, and, if married, the patient's spouse, prior to performance of the procedure. Where the sterilization is to be performed upon a dependent minor, written consent shall be obtained from the patient's sponsor, parents, or legal guardian.²¹

5. Federal Financial Support: No estimate of expenditures for family planning service under FHPS/HSMHA is available.

Footnotes to "The Federal Uniformed Services"

1. *Federal Register*, "Title 32—National Defense, Chapter V—Department of the Army, Part 577—Medical and Dental Attendance, Uniformed Services Health Benefits Program," (Washington, D.C.: Government Printing Office, April 8, 1971), p. 6714.
2. *Ibid.*, p. 6719.
3. *Ibid.*, p. 6718.
4. *Ibid.*, p. 6721.
5. *Code of Federal Regulations*, Revised as of January 1, 1971, "Title 32—National Defense, Chapter 1—Office of the Secretary of Defense, Part 70—Medical Care for Dependents of Members of the Uniformed Services," (Washington, D.C.: Government Printing Office, 1971), pp. 99–100.
6. *Op. Cit. Federal Register*, p. 6727.
- 6a. Statement of President Richard M. Nixon, April 3, 1971.
7. Department of the Army Message 794724, Subject: *Policy Guidelines on Family Planning Services*, December 21, 1966, p. 4.
8. Department of the Army Message 122040Z Jan. 71, Subject: *Policy for Family Planning Program*, January 12, 1971, p. 3.
9. *Ibid.*, p. 4.
10. Secretary of the Navy Instruction 6300.2A, Subject: *Family Planning Services; Contraception, Sterilization, and Abortion*, May 4, 1971, p. 1.
11. *Ibid.*
12. *Ibid.*
13. Department of the Air Force Policy Letter, Subject: *Family Planning Services*, December 9, 1966, p. 1.
14. *Ibid.*, Attachment 1.
15. Air Force Regulation 160–12, *Medical Service, Professional Policies and Procedures*, July 16, 1971, p. 15.
16. *Ibid.*
17. *Ibid.*
18. Public Health Service, *Federal Health Programs Service Operations Manual*, FHPSO Transmittal Letter No. 27, April 20, 1971, pp. 2 and 3.
19. *Ibid.*
20. *Ibid.*
21. *Ibid.*, p. 3.

EMERGENCY EMPLOYMENT ACT

A. General Purposes and Provisions of the Law

The Emergency Employment Act (EEA) of 1971 provides "unemployed and underemployed persons with transitional employment in jobs providing needed public services during times of high unemployment and, whenever feasible, related training and manpower services to enable such persons to move into employment or training not supported" by the act.

There are two major public service employment programs which are established by the law. They are detailed by four sets of regulations and by five guideline manuals issued by the Department of Labor.

The law defines as eligible participants in the programs, unemployed and underemployed persons

... who are available for work; and ... adults who or whose families receive money payments pursuant to a State plan approved under Title I, IV, X, or XVI of the Social Security Act ... and other criteria to be established by the Secretary.¹

... who are working part-time but seeking full-time work;
... persons who are working full-time but receiving wages below the poverty level established by OMB.²

The law provides that not less than 85 percent of the appropriated funds shall be expended only for wages and employment benefits to the persons employed under these programs.

Of the two programs established by the law, the largest is that which provides grants for transitional employment programs when the nation experiences an unemployment rate of 4.5 percent for three consecutive months. This program has two parts: One part, is administered by the states which receive funds from the Department of Labor on the basis of a formula written into the law; the remaining funds from the Department of Labor on the basis of a formula written into the law; the remaining part is administered by the Secretary of Labor who is given the discretionary authority to grant some employment funds directly to eligible applicants. He may use up to one-fifth of the program funds for this purpose.

The law specifies that "only units of Federal, State, and general local government, public agencies and institutions which are subdivisions of State or general local government, and institutions of the Federal government; or Indian tribes on Federal or

state reservations are eligible to apply for grants under this program."³

A second program authorizes special employment assistance in areas determined by the Secretary to have experienced an unemployment rate equal to or in excess of six percent for three consecutive months.

The law stipulates again that only a "... unit or combination of units of general local governments or any public agency or institution which is a subdivision of any such unit, or an Indian tribe on a Federal or State reservation, which is or has within it an area of substantial unemployment ..." may apply for funding under this program.⁴

The regulations for this program state that eligible applicants, "... [do] not include a State or any State or Federal agency or institution."⁵

1. Family Planning Provisions: Public service jobs are defined in the law to include work in the field of voluntary family planning services:

... 'public service' includes, but is not limited to, work in such fields as environmental quality, health care, education ... and other fields of human betterment and community improvement.

... 'health care' includes, but is not limited to, preventive and clinical medical treatment, voluntary family planning services, nutrition services, and appropriate psychiatric, psychological, and prosthetic services.⁶

In addition, the law provides that program applications shall include provisions describing how trainees and persons employed in public service jobs will receive "... where appropriate, the education, training and supportive services (including counseling and health care services) which complement the work performed."⁷ Such health care services, as defined by the law, include voluntary family planning services.

2. Services to be Provided: Under the transitional employment program, the guidelines for the state-administered part of the program state that supportive services, including family planning, must be provided "... only where absolutely necessary to enable unemployed persons to obtain appropriate jobs."⁸

The Department of Labor has established a Welfare Demonstration Project; its funds are directly administered by the Secretary. The *Program Guidelines* for the project state:

For the purposes of this demonstration, EEA funds may not be used to provide supportive or manpower services. In low support models, only supportive services to which the welfare recipient is entitled through the welfare system will be provided . . . In high support models, a full array of supportive and manpower services (including, but not limited to, child care, work-related expenses, medical services . . .) will be provided through the WIN [Work Incentive] Program in cooperation with the local welfare agency. Therefore, it is imperative that the Program Agent, Subagents, and employing agencies establish and maintain the necessary linkages with the appropriate agency, to assure the adequate and timely provision of supportive services.⁹

In regard to supportive services, the guidelines for the Special Employment Assistance program state:

It is anticipated that most areas designated to receive funds under Section 6 of the Act will be areas which have experienced long periods of chronic unemployment and underemployment among its residents. In many cases urban areas populated by minority groups in inner city ghettos and barrios and rural areas and Indian reservations will be eligible for assistance under the program.

Program Agents should make every effort to link with existing programs designed to reach and meet the needs of the target population for the provision of administrative, and, where possible, supportive services. . . .¹⁰

3. Federal Financial Support; Administration and Expenditures: Programs under this act are adminis-

tered by the Department of Labor's Manpower Administration, which is also responsible for the WIN (See discussion and Profile for Title IV-A, above).

The federal share for both programs is 90 percent; the 10 percent nonfederal share may be contributed in cash or in kind.¹¹

A total of \$1 billion was authorized and appropriated for these programs in FY 1972. The authorization for FY 1973 is \$1.25 billion.

Footnotes to "Emergency Employment Act"

1. Emergency Employment Act of 1971, PL 92-54, July 12, 1971, § 14 (a) (5) (6) .
2. Op. Cit. § 14 (a) (6) .
3. Ibid. § 4.
4. Ibid. § 6 (c) (2) .
5. *Federal Register*, Vol. 36, No. 193 October 5, 1971, p. 19364.
6. Op. Cit. PL 92-54 § 14 (a) (3) (4) .
7. Ibid. § 7 (c) (11) .
8. *Emergency Employment Act Program Guidelines*, U.S. Department of Labor, Manpower Administration, August 12, 1971, X. "Manpower Services."
9. *Program Guidelines for the Welfare Demonstration Project Emergency Employment Act*, U.S. Department of Labor, Manpower Administration, October 22, 1971, X. "Manpower Services."
10. *Program Guidelines for Section 6 of the Emergency Employment Act*, U.S. Department of Labor, Manpower Administration, September 20, 1971, V. "Linkages with other programs," p. 11.
11. Op. Cit., Emergency Employment Act of 1971, P.L. 92-54, § 8.

FEDERAL FOOD, DRUG AND COSMETICS ACT

A. General Purposes of the Law, and Provisions Affecting Contraception

The Food and Drug Administration of the Department of Health, Education and Welfare (FDA/DHEW) in administering the Federal Food, Drug and Cosmetics (FDC) Act regulates the quality and purity,¹ and the packaging and labeling² of drugs, including contraceptive drugs and devices³ (including IUDs, condoms, and diaphragms) which are imported or shipped in interstate commerce. The Act also provides protection to the public by requiring that "new drugs" be proved safe and effective⁴ before the FDA will approve them for sale upon the market.

1. **New Drugs:** The law requires, so far as new drugs are concerned, that "... reports be filed with FDA by the manufacturer or the sponsor of the investigation of such drug, on preclinical tests (including tests on animals) of such drug adequate to justify the proposed clinical testing..." The manufacturer or sponsor of the investigation must also maintain strict supervision of patients and accurate records of such investigation.⁵ Until now, such requirements were not held to regulate research into new IUDs. However, the FDA has now proposed that IUDs utilizing heavy metals, drugs or other added substances be classified as "new drugs," subject to the above requirements. If this proposal is adopted, it would be required that a "Notice of Claimed Investigation Exemption for a New Drug" be submitted for the approval of the FDA for the purpose of conducting clinical research to determine if such devices are safe and effective for contraceptive use in humans.⁶ Such procedures are already required with respect to "new drugs" such as pills or vaccines as distinguished from new "devices."

2. **Adulteration and Misbranding:** The FDC Act prohibits the introduction into interstate commerce of "adulterated" or "misbranded" drugs or devices;⁷ such prohibited acts may be enjoined upon application to the United States District Courts.⁸ The statute also provides for imprisonment and/or fines for violations of such prohibited acts.⁹ The law also authorizes the seizure of "adulterated" or "misbranded" drugs or devices introduced into interstate commerce.¹⁰

An "adulterated" drug or device, as defined by the FDC Act, is one whose "strength differs from, or its purity or quality falls below, that which it purports or is represented to possess."¹¹ In the case of *Gellman Bros. v. United States*,¹² the court, in interpreting Section 501(c) of the Act held that a shipment of rubber devices labeled "prophylactics" was properly condemned as "adulterated" when representative samples showed that the shipment included a substantial percentage of "leakers," possessing holes not discernible to the naked eye but "of such size as to permit the passage of disease germs to and fro." In *United States v. Dean Rubber Manufacturing Co.*¹³ the U.S. Court of Appeals for the Eighth Circuit held that rubber prophylactics which were claimed to "aid in the prevention of venereal disease" were "adulterated" since these devices failed to meet the standards with which they purported to comply.

Under the Food, Drug and Cosmetics Act a drug or device is deemed to be "misbranded" if its "labeling is false or misleading in any particular,"¹⁴ or if it does not include adequate warnings of potential health hazards.¹⁵

Acting under the authority of this provision, the FDA published regulations in June, 1970 in the *Federal Register* pertaining to the labeling of oral contraceptives, including the requirement of a warning (to be included in each package of pills) against the use of such products by women with certain physical conditions.¹⁶

These regulations are being challenged as inadequate in *Turner v. Edwards*,¹⁷ a class suit brought by plaintiffs on behalf of all women who are presently taking or considering taking oral contraceptives. The FDA's June 1970 regulations require a short warning about the hazards associated with the use of the pill to accompany each package of oral contraceptives, with a pamphlet containing detailed warnings available to physicians for distribution to their patients. Plaintiffs seek to have the FDA require that drug manufacturers include in each package more detailed warnings than now required which would list the potential side effects and symptoms of trouble. A preliminary injunction to require the FDA to so act was refused on the grounds that plaintiffs had not shown a substantial likelihood that they will ultimately prevail on the merits.

3. **Administration of the Law:** The regulations promulgated on the basis of the Food, Drug, and Cosmetics Act are administered by the FDA's Bureau of Drugs.

Footnotes to "Federal Food, Drug and Cosmetics Act"

1. Food, Drug and Cosmetics Act § 401, 21 U.S.C. 351 (1971) .
2. Food, Drug and Cosmetics Act § 502, 21 U.S.C. 352 (1971) .
3. "The term 'device' . . . means instruments, apparatus, and contrivances, including their components, parts, and accessories, intended (1) for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; or (2) to affect the structure or any function of the body of man or other animals." Food, Drug and Cosmetics Act §201 (h) , 21 U.S.C. 321 (h) (1971) .
4. Food, Drug and Cosmetics Act § 201, 21 U.S.C. 355 (1971) .
5. Published in 36 F.R. 10983, June 5, 1971.
6. Food, Drug and Cosmetics Act § 201, 21 U.S.C. 355 (1971) .
7. 21 U.S.C. § 331.
8. Food, Drug and Cosmetics Act § 302, 21 U.S.C. 332 (1971) .
9. Food, Drug and Cosmetics Act § 303, 21 U.S.C. 333 (1971) .
10. Food, Drug and Cosmetics Act § 304, 21 U.S.C. 334 (1971) .
11. 21 U.S.C. 351 (b) (1971) .
12. 159 F. 2d 881 (8th Cir. 1947) .
13. 356 F. 2d 161 (8th Cir. 1966) .
14. Food, Drug and Cosmetics Act § 502 (a) , 21 U.S.C. 352 (a) (1971) .
15. Food, Drug and Cosmetics Act § 502 (f) , 21 U.S.C. 352 (f) (1971) .
16. 21 *CFR* 130.45, June 11, 1970.
17. U.S. District Court for District of Columbia, Civil Action 1997-70, in F.D. Cosm. L. Rep. paragraph 40, 422.

THE FEDERAL 'COMSTOCK LAWS'

A. General Purposes and Provisions of The Comstock Laws

The 'Comstock laws'¹ named after their principal advocate, Anthony Comstock, were originally passed by Congress in 1873. These laws prohibit mailing, shipping, or importation of "obscene" or "immoral" matter which, until 1971, was defined to include articles, drugs, or medicines for the prevention of conception and, in part, the dissemination of printed materials about contraceptives. As originally proposed, the Comstock laws contained an exemption for physicians from that portion of the legislation which prohibited the possession, sale or mailing of contraceptive devices. However, an amendment to the bill, striking out the exemption, was introduced and passed on the floor of the Senate.²

1. Judicial Interpretation: As applied to contraceptives, the Comstock laws were judicially and administratively interpreted in numerous cases and administrative rulings over the years which read into the statutory language many specific exemptions. For example, in *Youngs Rubber Corp. v. C. I. Lee & Co.*, 45 F. 2d 103 (2d Cir. 1930) the court pointed out if the statutory language were to be taken literally it would "forbid the transportation by mail or common carrier of anything . . . suitable . . . for preventing conception or for any indecent or immoral purpose even though the article might also be capable of legitimate uses,"; e.g., a physician desiring to use a contraceptive for proper medical purposes. The court refused to so interpret the statute, saying it only applied where there was an intent on the part of the sender that the article mailed or shipped be used for illegal contraception or for indecent or immoral purposes.

In *United States v. One Package*, 86 F. 2d 737 (2d Cir. 1936) the court held that the Comstock laws did not prevent the mailing, importation or sale of things "which might intelligently be employed by conscientious and competent physicians for the purpose of saving life and promoting the well-being of their patients." *Consumer's Union v. Walker*, 145 F. 2d 33 (D. C. Cir. 1944) held that a report evaluating various contraceptive materials could be sent to "properly qualified people" without violating the laws. In *U.S. v. Nicholas*, 97 F. 2d 510 (2d Cir. 1938) the court ruled that the importation or sending through the mails of contraceptive articles or

publications is not forbidden absolutely, and did not apply where they were being sent to appropriate qualified personnel. *U.S. v H. L. Blake*, 189 F. Supp. 930 (D.C. Ark. 1960) involved a defendant who mailed a parcel containing a vending machine and prophylactics. The court held that the Government had the burden of proving that the articles involved were designed to be used for the prevention of conception rather than the prevention of disease.

2. Departmental Regulation: During the 1960s, many agencies of the federal government, including the Post Office Department, advocated deleting reference to articles for the prevention of conception from these laws, recognizing that the various rulings which allowed the mailing of contraceptives under conditions described as "for lawful purposes" had made the laws unenforceable. Postmaster General Winton M. Blount, in formal testimony, also recognized the changing conditions whereby many states now authorized or encouraged family planning programs. He stated: "The dissemination of contraceptive information has become a widely accepted practice, and the delivery by mail of contraceptive information or materials has by court decisions and administrative rulings based on such decisions, been considered proper in cases where a lawful and permissive purpose is present."³

3. Legislative Amendment: Climaxing this increasingly broad interpretation of the Comstock laws, in January 1971 the Congress passed amendments (introduced by Congressman James H. Scheuer, D-NY), which deleted from these laws all reference to articles for the prevention of conception.⁴ However, Congress at the same time added a new section designating as "nonmailable matter" contraceptives and printed materials concerning contraceptives which are not solicited by the addressee. An exception is made for contraceptive samples and advertisements for contraceptives mailed to manufacturers and dealers in contraceptives, physicians, surgeons, nurses, pharmacists, druggists, hospitals and clinics. The new section also includes a provision which states that "an advertisement shall not be deemed to be unsolicited if it is contained in a publication for which the addressee has paid or promised to pay or which he has otherwise indicated he desires to receive."⁵

The prohibition of unsolicited contraceptives and printed materials about contraceptives as "nonmailable matter," is now the only federal restriction on the distribution of contraceptives which have been approved by the Food and Drug Administration (See Profile on Federal Food, Drug and Cosmetics Act).

The amendment has been implemented by a regulation of the Postal Service, Postal Service Manual Section 123.72.

4. Administration of the Law: These provisions are administered through the joint efforts of four units of the U.S. Postal Service. Three of these units are located on the staff of the Postmaster General. Consumer complaints are directed to the Consumer Advocate of the Postal Service. Questions regarding the legality of mailings should be directed to the Assistant General Counsel of the Postal Service, Consumer Protection Office, Law Department. If it appears that a violation has occurred, the Assistant Postmaster General for Postal Inspection is contacted either by the Consumer Advocate or the

Assistant General Counsel to initiate an investigation and carry out enforcement of the law, if necessary. If it is determined that there is a question regarding the classification of matter or materials, the Division of Mail Classification, Support Group, a bureau of the Postal Service, would handle any reclassification.

Footnotes to "The Federal 'Comstock Laws'"

1. Title 18 § 1461, relating to mailing obscene or crime-inciting matter; Title 18 § 1462, relating to importation or transportation in interstate commerce of obscene matter; Title 19 § 1305, relating to importation and transportation in interstate commerce of immoral articles; and Title 18 § 552, relating to U.S. officers and employees aiding in the importation of obscene or treasonous books and articles.
2. See discussion in Peter Smith, "The History and Future of the Legal Battle over Birth Control," 49 Cornell L.Q. 275 (1964).
3. H.R. Report No. 91-1105, pp. 3-4 (Committee on Ways and Means, "Articles Intended for Preventing Conception").
4. P.L. 91-662 (See footnote 1, above).
5. Ibid. tit. 39, § 4001 (now 3001).

Summary and Analysis of State Laws Relating to Contraception

General Status of Laws Relating to Contraception

Since the mid-1960s there has been a veritable revolution in state laws relating to family planning services, and the sale, distribution and dissemination of information (including advertising and display) about contraceptives.

Whereas the history of state laws concerning birth control prior to that time had been dominated by restrictions and prohibitions patterned on the late nineteenth century 'Comstock Laws' (See Federal Laws and Policies Section, above), the trend since the mid-1960s has been to affirm state support of freer access to voluntary family planning information and services, and to establish family planning programs for state residents.

Almost half the states which had restrictive laws before the mid-1960s—16 states in all—have since repealed or liberalized their restrictive laws.¹ Eighteen states² and the District of Columbia adopted legislation authorizing state agencies to administer family planning programs. In a total of 28 states³—including 12 of the states with laws authorizing family planning programs—there is no statute at present restricting in any way the dissemination of information about, or the sale or distribution of, contraceptives to any person.

Of the remaining 22 states with some restrictions, three states—Louisiana, Nebraska and Pennsylvania—only prohibit the sale or advertising of "secret" drugs or nostrums to prevent conception, but since marketed contraceptives are hardly "secret," these statutes would appear to have little or no effect; Maine's only prohibition is against refilling prescriptions for oral contraceptives "from a copy of the original prescription"; Maryland and North Dakota prohibit vending machine sales of contraceptives only; Texas forbids sales of contraceptives "on streets and public places" by persons other than doctors or pharmacists; New Jersey prohibits the sale, advertising or display of contraceptives "without just cause," a statute which has been interpreted liberally by the courts. Most of the other laws regulate who may sell or distribute contraceptives (most often limited to pharmacists, physicians, hospitals, clinics and health agencies), or where and how they may be advertised or displayed. New York prohibits the sale of contraceptives to persons younger than

16, but this restriction does not apply to physicians. Wisconsin has a statute which forbids the sale or distribution of contraceptives to persons who are not married. Massachusetts had a similar provision in its statute which was declared unconstitutional by the United States Supreme Court (see discussion, below). Only three states—Indiana, South Dakota and Wisconsin—expressly forbid all dissemination of information about contraception, but these statutes are apparently subject to exceptions in practice and are not enforced generally; if they were, they would probably be subject to attack on First Amendment grounds.

The Griswold Case

Prior to 1965 many states had 'little Comstock laws' prohibiting or placing restrictions on the sale, advertising or display of "articles for the prevention of conception." Only Connecticut had a law actually prohibiting the use of contraceptives. In 1965, the United States Supreme Court in the *Griswold*⁴ case recognized the right of married persons to practice birth control. In a case challenging the constitutionality of the Connecticut statute which forbade the use of contraceptives, the court held the statute to be violative of the right of marital privacy and, therefore, unconstitutional. Subsequently the case has been considered authority for the proposition that there is a right of privacy in matters relating to marriage, sex and the family. Since the *Griswold* decision at least 13⁵ states have repealed or substantially liberalized their anticontraception laws. In this respect the *Griswold* case may be considered a bench mark, dividing an era dominated by laws restricting the availability of contraception from the era which actually encourages convenient access to and availability of family planning services.

Affirmative Laws

Of the 18 states which had affirmative family planning laws as of September 1, 1971, 10 had no statutory restrictions as to which residents of the state should be served by the state-administered programs authorized by the statutes⁶; seven set up programs for indigent persons only (usually welfare clients),⁷ and three (California, Oklahoma and Ore-

gon) had separate provisions covering indigent persons and all others.

Most of these 18 states have laws which call for programs providing a full range of medical family planning services, supplies and information. Four state statutes call for information and/or referral services only. Alaska calls for information only for "all persons"; California's law, while calling for the provision of full family planning services for indigent persons, permits only information and referral for persons who are not indigent. California also provides that all marriage license applicants be provided a list of family planning clinics in their county. Illinois permits referral for indigent persons only. Hawaii provides for information only for marriage license applicants. In all these states, however, the extent of the actual programs carried out under these statutes is determined in large part by the availability of funds.

Many of the family planning programs authorized by these affirmative laws are, in general, quite comprehensive. The Tennessee statute,⁸ for example, authorizes making medically acceptable contraceptive procedures, supplies and information readily and practicably available to persons desiring them regardless of sex, race, age, income, marital status, number of children, citizenship or motive. Colorado has a similar statute.⁹ Both statutes provide that services shall be conditioned on "the availability of funds."

Oklahoma¹⁰ and Kansas¹¹ authorize their state departments of health to establish family planning centers to furnish and disseminate information, means and methods of "planned parenthood" (Kansas), and to carry out clinical activities incident to child-spacing including medical examination, insertions of contraceptive devices and prescriptions of drugs (Oklahoma).

The significance of these affirmative family planning laws is that, despite the fact that a state may have no laws against furnishing family planning services, many people still lack access to effective means of controlling their fertility. This may be because they cannot afford to purchase family planning services from private physicians; they may lack information about what are the most effective methods; there may be no facility providing family planning services located conveniently to them; their physicians may have religious or other conscientious objections to providing them with contraceptives, or they may be deterred from seeking service if they are minors or unmarried because of fear of censure from their physicians or families. Government-subsidized family planning services are essential for these groups and others who have similar access difficulties and who might otherwise be subjected to unwanted pregnancy and childbearing.

Laws Relating to Sale and Distribution of Contraceptives

As of September 1971, there were 34 states¹² in which there was no law restricting or regulating¹³ the sale or distribution of contraceptives.¹⁴ The number of states with no laws on contraception has been increasing steadily since 1965 and the clear trend is toward the removal of all such barriers to the sale and distribution of contraceptives.^{14a}

Statutory restrictions in the 16 remaining states vary from licensing requirements for those who may sell contraceptives, to limitations on distribution by certain categories of persons, to outright prohibitions against distribution of contraceptives by vending machines.¹⁵

Three states¹⁶ have no restrictions on sale or distribution other than prohibiting the sale of contraceptives by vending machines. One state, Maryland, makes an exception, permitting sale by vending machine in certain places where alcoholic beverages are sold for consumption on the premises.¹⁷ Maine forbids the selling of prescriptions for oral contraceptives "from a copy of the original prescription."¹⁸ Twelve states¹⁹ have statutes restricting or regulating the sale or distribution of contraceptives in other respects; of these, six²⁰ also expressly restrict sale of contraceptives by vending machine, and two, New Jersey and Iowa, restrict such vending machine sales by inference.²¹

Insofar as they restrict sale or distribution of contraceptives other than by vending machine, all of these state statutes (except Nebraska, see below) contain provisions exempting, or they have been construed to exempt, certain categories of persons (the most frequent being physicians, medical practitioners, and registered pharmacists) from the provisions of the statute. The result is that sale and distribution of contraceptives, at least by doctors and/or pharmacists, are legal in every state, although Wisconsin provides that sales and distribution can be made only to married persons.

Until recently, Massachusetts also provided that distribution of contraceptives could be made to married persons only. However, the Massachusetts statute, which permitted dispensation of "drugs and articles for use in birth control" only on a physician's prescription and only to married persons,²² was held unconstitutional by the United States Supreme Court on March 22, 1972, in *Eisenstadt v. Baird*. 40 U.S. Law Week 4303 (March 21, 1972). A majority of the Court, in an opinion in which four justices joined, held that the statute's prohibition against the distribution of contraceptives except to married persons violated the rights of single persons under the Equal Protection Clause of the Fourteenth Amendment. Two justices, while joining in the result reached by the majority, wrote a separate opinion stating their view that the statutory requirement

that contraceptives be dispensed only on a physician's prescription could not be sustained in the absence of proof that Emko Vaginal Foam, the contraceptive for the distribution of which Baird was convicted, was hazardous to health.

The Wisconsin statute makes it a misdemeanor to sell or dispose of contraceptives "to or for any unmarried person."²³ The United States Supreme Court decision in *Eisenstadt v. Baird*, supra, casts doubt on the validity of this provision.²⁴ (See State Profile, Wisconsin). For a discussion of restrictions relating to minors, see Summary and Analysis of State Laws Relating to Contraceptive Services to Minors, below.

Dissemination of Information, Advertising and Display

As of September, 1971, there were 33 states²⁵ in which no law restricted the dissemination of information (including advertising and display) about contraceptives. Three more states (Louisiana, Nebraska and Pennsylvania) had statutes restricting the advertising only of "secret" nostrums or drugs to prevent conception (See below). Of the remaining 14 states²⁶ with statutes containing some restriction on advertising, most have provisos exempting certain categories of advertisements from the statutory prohibitions; the most frequent permissible advertisements on contraceptives are those in medical and pharmaceutical publications, and those in "literature enclosed in and around the original package."²⁷

Looking at display alone, as of the same date, there were 41 states²⁸ where no laws restricted the display of contraceptives. Of the remaining nine states²⁹ with restrictions, some, such as New Jersey³⁰ and Oregon³¹ have liberalized the restrictions of the law by judicial interpretation, and in others, the State Attorney General has published opinions tending to limit the extent of the apparent restriction on display.³²

Restrictions on the advertising, display or dissemination of information about contraceptives are sometimes challenged on First Amendment grounds.

For example, the Massachusetts statute prohibits exhibiting, advertising and circulating written information on contraceptives.³³ In *Baird v. Eisenstadt*³⁴ that part of the statute prohibiting the exhibition of contraceptives was held by the Massachusetts Supreme Court to be a violation of the First Amendment. Moreover, in an increasing number of cases, including *Griswold*, courts have recognized that the First Amendment protects the rights of those who wish to *receive* information, as well as the rights of those who wish to disseminate information.³⁵ It seems likely that within the near future, the validity of state statutes restricting advertising, display or dissemination of information on contraceptives will

be resolved through a case which permits the courts to assess these issues.³⁶

Limiting of the Scope of State Restrictive Statutes

Though many of the state statutes which regulate distribution or restrict advertising or display of contraceptives have language that seems quite broad, judicial interpretations and Attorneys General's opinions have tended to limit their scope. For example, in Arizona, a statute prohibiting advertising or giving any medicine or means for the prevention of conception³⁷ was construed to permit the dissemination of birth control information by a doctor to his patient or by Planned Parenthood. "Advertising" was limited to public commercial announcements advocating specific trade brands. *Planned Parenthood Committee of Phoenix, Inc. v. Maricopa County*, 92 Ariz. 231, 375 P. 2d 719 (1962).

In Iowa, where a statute prohibits the advertising, sale or distribution of any "article or thing designed or intended for . . . preventing conception," except for the regular practice of doctors or druggists,³⁸ the Attorney General has stated that literature pertaining to birth control is not such an "article or thing" within the meaning of the statute and thus may be circulated freely, provided it is not an actual advertisement for a trade branded article. *Op. Atty. Gen. 1970, # 70-3-35*.

Louisiana and Nebraska have statutes that refer to "secret" drugs, nostrums and medicines. Nebraska's statute prohibits sale of "secret" nostrums, drugs or medicines for preventing conception.³⁹ The Nebraska Supreme Court ruled in 1965 that if a nostrum, drug or medicine is not "secret," the statute is not violated.⁴⁰ Since most contraceptives are not secret, the statute would seem to have little effect upon their sale or distribution. It is interesting to note moreover that not only are contraceptives sold in Nebraska,⁴¹ but also the State of Nebraska distributes family planning information and services to its welfare recipients, clearly indicating a state policy in favor of distribution of contraceptives, and a lack of "secrecy" with respect to those contraceptives that are distributed. The Louisiana statute prohibits the "advertising of any secret drug or nostrum exclusively for the use of females for preventing conception."⁴² A Louisiana Attorney General's opinion in 1965 narrowed the effect of the Louisiana statute by ascribing to "secret" its usual meaning, thereby permitting distribution generally.⁴³ Before this 1965 opinion a 1934 opinion had interpreted the law as making illegal the manufacture, distribution or sale of contraceptives in Louisiana.⁴⁴

In New Jersey, a statute prohibits any person "without just cause" from selling, advertising or displaying contraceptives.⁴⁵ The New Jersey Supreme Court has interpreted this to permit the display of

contraceptives to a woman in a van parked in a municipal parking lot, incidental to an explanation of birth control.⁴⁶ Thus, display incidental to oral explanation of birth control is considered to be with "just cause."

In *Poe v. Ullman*, 367 U.S. 497, 81 S.Ct. 1752, 6 L. Ed. 2d 989 (1961), decided four years before the *Griswold* case struck down the Connecticut anti-birth control statute as unconstitutional, the Supreme Court interpreted the situation in Connecticut, where there had been only one recorded prosecution under the statute in the 75 years since its enactment and found that the lack of recorded prosecutions and the unchallenged, open, ubiquitous public sales of contraceptive devices showed a deeply embedded state policy amounting to a tacit agreement on the part of the state not to prosecute violators of the statute.

These situations typify ways in which administrative and law enforcement officials have in effect modified statutes restricting the sale, advertising and display of contraceptives despite legislative inaction.

Conclusion

Dissemination of information about contraceptives is lawful in all states under applicable judicial authority interpreting the First Amendment to the Constitution. Sale or distribution of contraceptives is permitted under the law of all states. Existing restrictive legislation, for the most part, regulates who may sell or distribute contraceptives and the conditions under which they may be advertised or displayed. The clear trend is toward elimination of state statutory restrictions.

An increasing number of states now have affirmative legislation establishing family planning programs. Some states restrict these services to the indigent; others authorize services to be provided for persons desiring them regardless of economic status.

Footnotes to "State Laws Relating to Contraception"

1. California, Delaware, Illinois, Kansas, Mississippi, Missouri, Nevada, Ohio, Washington, and Wyoming repealed their restrictive laws. Indiana, Minnesota, Maine, Massachusetts and New York liberalized their laws. Connecticut's law was overturned as the result of the *Griswold* decision.
2. Alaska, California, Colorado, Georgia, Hawaii, Illinois, Iowa, Kansas, Louisiana, Michigan, Nevada, New York, Ohio, Oklahoma, Oregon, Tennessee, West Virginia, Wyoming.
3. Alabama, Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Kentucky, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia and Wyoming.
4. *Griswold v. Connecticut*, 381 U.S. 479 (1965).
5. All in 1. above, except Indiana and Kansas whose statutes date from 1963, and, of course, Connecticut.

6. Alaska, California, Colorado, Georgia, Kansas, Nevada, Oklahoma, Oregon, Tennessee, Wyoming.
7. Illinois, Iowa, Louisiana, Michigan, New York, Ohio, West Virginia.
8. Senate Bill No. 871 Chap. No. 400, Public Acts of 1971.
9. Colo. Rev. Stat. Ann. §§ 66-32-1 to 66-32-3 (1971 Supp.).
10. Okla. Stat. tit. 63, §§ 2071 to 2074 (1967 Supp.).
11. Kan. Stat. Ann. § 23-501 (1970 Supp.).
12. Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming.
13. "Restrict" is used herein to indicate an actual prohibition, while "regulate" is used to indicate permission under certain specified conditions.
14. Note that this tabulation refers to state laws on contraceptives. Several states have separate laws on prophylactics, defined as drugs or devices to prevent venereal disease, i.e. condoms; but these are not included in these figures. Condoms can be used both for the prevention of venereal disease, and for the prevention of conception. Some question whether condoms, intended for use in the prevention of conception, would be regulated in those states with statutes on prophylactics. Most states would probably retain the distinction, with only a few blurring the distinction. See individual states profiles on this question.
- 14a. In *Eisenstadt v. Baird*, 40 U.S. Law Week 4303, March 21, 1972 (in which the Supreme Court struck down the Massachusetts birth control law), the question of state restrictions on distribution of contraceptives was discussed. The majority and concurring opinions noted that the requirement in the Massachusetts statute of a doctor's prescription for all kinds of contraceptives for married persons even if the contraceptives were not potentially dangerous made the statute "overbroad." It seems reasonable to conclude that if the Massachusetts statute had not distinguished between married and unmarried persons, but had been challenged solely on the basis that it required all persons to have a doctor's prescription for all contraceptives, the same Court would have held it unconstitutional as overbroad. The opinion of the concurring Justices also suggests that a state requirement that all contraceptives be obtained either from a physician or from a licensed pharmacist would be unconstitutional. Such a decision could be of great practical importance because in rural areas, for example, pharmacies are not readily accessible. If distribution of nonprescription items such as condoms and foams, which present no apparent health hazard, were limited to physicians and pharmacists, this would effectively inhibit the ability of many persons to obtain contraceptives and thus in effect violate the constitutional right to use contraceptives, as guaranteed by *Griswold*.
15. The following 12 states have laws regulating or restricting the sale or distribution of prophylactics: California, Colorado, Hawaii, Idaho, Kentucky, Maine, Michigan, Nebraska, Pennsylvania, Utah, Virginia, Washington.
16. Maryland, North Dakota, South Dakota.
17. Hawaii and Pennsylvania have no restrictions on sale and distribution of prophylactics other than prohibiting sale by vending machine.
18. Me. Rev. Stat. Ann. tit. 22, § 2212-A (1971).
19. Arkansas, Idaho, Iowa, Massachusetts, Minnesota, Montana, Nebraska, New Jersey, New York, Oregon, Texas, Wisconsin.
20. Arkansas, Idaho, Massachusetts, Minnesota, Montana, Oregon.

21. New Jersey's statute prohibits sale and distribution of contraceptives "without just cause," N.J. Rev. Stat. § 2A: 170-76 (Supp. 1953). In several cases, New Jersey courts have assumed that this limitation applies to sale by vending machine. Iowa's statute prohibits the sale or giving away of contraceptives, Iowa Code § 725.5 (1966). An Iowa Supreme Court case held this statute applicable to sales by vending machines.
22. Mass. Gen. Laws Ann. Ch. 272, §§ 20, 21, 21A (1966 Supp.).
23. Wis. Stat. § 450.11 (4) (1969).
24. In *Griswold v. Connecticut*, 381 U.S. 479 (1965), the right of married persons to practice birth control was established. Since then a number of lower court cases have construed *Griswold* as having recognized the "fundamental right of a woman to choose whether or not to bear children." See, e.g., *People v. Belous*, 71 Cal. 2d 954, 80 Cal. Rptr. 354, 458 P. 2d 194 (1969), cert. denied 397 U.S. 915 (1970). A majority consisting of four justices of the United States Supreme Court held in *Eisenstadt v. Baird*, 40 U.S. Law Week 4303 (March 21, 1972), that "whatever the rights of the individual to access to contraceptives may be, the rights must be the same for the unmarried and the married alike."
25. Alabama, Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming.
26. Arkansas, Arizona, Hawaii, Idaho, Indiana, Iowa, Massachusetts, Michigan, Montana, New Jersey, New York, Oregon, South Dakota, Wisconsin.
27. Eight states have laws restricting the advertising of prophylactics: California, Colorado, Hawaii, Idaho, Kentucky, Michigan, Utah, West Virginia.
28. Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming.
29. Arkansas, Idaho, Massachusetts, Montana, New Jersey, New York, Oregon, South Dakota, Wisconsin.
30. See *State v. Baird*, 50 N.J. 376, 235 A. 2d 673 (1967).
31. See Op. Atty. Gen. 1971, No. OP-0227.
32. In addition to those states with laws restricting display of contraceptives, seven states have laws restricting the display of prophylactics: California, Colorado, Idaho, Kentucky, Michigan, Nebraska, Utah.
33. Mass. Gen. Laws Ann. Ch. 272, §§ 20, 21 (1966 Supp.).
34. 355 Mass. 746, 247 N.E. 2d 574 (1969).
35. *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Stanley v. Georgia*, 394 U.S. 557 (1969); *Red Lion Broadcasting Co. v. F.C.C.*, 395 U.S. 367 (1969); *N.Y. Times Co. v. Sullivan*, 376 U.S. 254 (1964); *Martin v. City of Struthers*, 319 U.S. 141 (1943); *Mandel v. Mitchell*, 325 F. Supp. 620 (1971).
36. One feature of a "right to hear and read" test to measure the validity of state statutes against display, advertising, and dissemination of information relative to contraceptives is that people who wish to know about contraception can initiate their own suits challenging the constitutionality of restrictive statutes; this eliminates the necessity on the part of those who wish to advertise or disseminate such information of risking criminal prosecution to test such statutes.
37. Ariz. Rev. Stat. Ann. § 13-213 (1956).
38. Iowa Code § 725.5 (1966).
39. Neb. Rev. Stat. § 28-423 (1964).
40. *State v. Lauritsen*, 178 Neb. 230, 132 N.W. 2d 379 (1965).
41. See T. R. Pansing, "Criminal law—Contraceptive Statutes—Prophylactic Control Act—Implied Repeal—Implied Exception," 19 Nebraska Law Bulletin 35 (1940).
42. La. Rev. Stat. § 14.88 (1950).
43. Op. Atty. Gen. 1965, p. 300.
44. Op. Atty. Gen. 1934-36, p. 73.
45. N.J. Rev. Stat. § 2A: 170-76 (Supp. 1953).
46. *State v. Baird*, 50 N.J. 376, 235 A. 2d 673 (1967).

Summary and Analysis of State Laws Relating to Voluntary Sterilization

The term "voluntary sterilization" is used in this report to denote a surgical procedure which is performed by a physician upon a person who requests it in order to obtain permanent protection from conception.¹

The most common surgical method for accomplishing voluntary sterilization of men is vasectomy, which is the surgical excision and/or ligation (tying off) of a portion of each vas deferens (the excretory ducts of the testes).

The most common surgical method for accomplishing voluntary sterilization of women is tubal sterilization, which is the surgical excision and/or ligation of portions of the oviducts, or fallopian tubes.

Vasectomy is a relatively simple procedure which can be performed in a doctor's office. Tubal sterilization via the new laparoscopic and culdoscopic techniques may also be performed as an outpatient or overnight stay procedure, but is generally performed in a hospital. The more traditional methods of female sterilization, involving the opening of the abdominal cavity, require a hospital stay of several days. (The term "salpingectomy" is generally used synonymously for tubal sterilization though it literally means the excision of the fallopian tubes). Both vasectomy and tubal sterilization are to be distinguished from castration, which is the surgical removal of the testes or ovaries, and from hysterectomy, the excision of the uterus, which procedures also result in sterilization.

Voluntary sterilization must be distinguished from "compulsory sterilization." Many states have statutes which provide for the sterilization of certain groups of people—usually inmates of state institutions who are afflicted with certain forms of insanity or mental deficiency—sometimes with, but sometimes without, the consent of the patient. These statutes are known as "compulsory sterilization laws," and are not within the scope of this study. Serious questions have been raised as to their constitutionality.

Voluntary sterilization may be performed for contraceptive (sometimes referred to as socioeconomic) reasons or for reasons of medical necessity. When performed for reasons of medical necessity, it is sometimes called "therapeutic sterilization." Therapeutic sterilization ordinarily denotes sterilization of a po-

tential mother, on her request, because of circumstances indicating that pregnancy would endanger her physical well being or health. Sterilization is generally regarded as therapeutic if the woman's psychological instability would seriously impair her ability to function as an adequate parent.²

The nature of a wife's condition may be "transferred" to the husband, as where surgery is contraindicated in the wife, or the couple decides on vasectomy of the husband as a less expensive form of voluntary sterilization.³ It is also possible for a man to have a vasectomy for reasons beneficial to his own physical health, as in connection with prostate surgery.

In view of the broadening concept of "health" which includes mental health,⁴ and the fact that voluntary sterilization for contraceptive purposes is generally beneficial to the mental health of persons who do not desire more children, the distinction between "therapeutic" and "contraceptive" voluntary sterilization would appear not to be important.

Is Voluntary Sterilization Legal?

Voluntary sterilization for all reasons is legal in all states with the possible exception of Utah and it is specifically affirmed as legal in the statutes, judicial decisions, Attorneys General's opinions and/or the state health and welfare policies of 44 states. A Utah statute may be read as prohibiting voluntary sterilization except for reasons of medical necessity.⁵ A recent lower court case in Utah held that this restriction applies only to the inmates of state institutions who are subject to Utah's compulsory sterilization statute; the case is now pending for decision on an appeal to the Utah Supreme Court.⁶ Similar statutes have been repealed in Connecticut and Kansas.⁷

Most states have no statute at all on the subject of voluntary sterilization. Nineteen states by statute either explicitly or implicitly authorize it. In 12 states, judicial decisions, and in eight states Attorneys General's opinions state that voluntary sterilization is consistent with public policy. Indeed, the important legal question today is not the legality of voluntary sterilization, which is generally recognized, but the right of individuals to compel physi-

cians and hospitals to perform such sterilization procedures on them.

Statutes Authorizing Voluntary Sterilization

Four states—Georgia,⁸ North Carolina,⁹ Virginia¹⁰ and Oregon¹¹ have statutes which specifically authorize voluntary sterilization. The first three state statutes prescribe detailed procedures which must be followed. Each requires that the procedure must be performed by a duly licensed physician or surgeon who must collaborate with at least one other licensed physician. In Virginia, the surgical methods authorized are vasectomy and salpingectomy; both must be performed in a licensed hospital. In North Carolina, the surgical methods authorized are surgical interruption of the vas deferens or fallopian tubes; the surgical interruption of fallopian tubes must be performed in a licensed hospital.

North Carolina and Virginia provide that the request for sterilization must be made in writing at least 30 days prior to the operation by the person to be sterilized and, if married, by his or her spouse.

Georgia, while not requiring the operation to be performed in a hospital nor prescribing a waiting period, does have a requirement of spousal consent for married persons. All three states provide at least one exception to the spousal consent requirement. In Georgia, the spousal consent requirement is waived if the spouse cannot be found after reasonable effort. North Carolina has four exceptions. They apply where: the spouse has been declared mentally incompetent; the spouses are divorced; a separation agreement has been entered into; or the wife, who is seeking the operation, furnishes an affidavit that her husband abandoned her and failed to contribute to her support for at least the preceding six months. In Virginia, the spouse's consent is not necessary if the person seeking sterilization states in writing under oath that his or her spouse has disappeared or that they have been separated continuously for a period of more than two years prior thereto.

Each state requires that, prior to or at the time of the request for sterilization, a full and reasonable medical explanation must be given by the physician to the patient as to the meaning and consequences of the operation.

All three states exempt licensed physicians performing authorized sterilization procedures from criminal or civil liability except for negligence.

Oregon's statute specifically provides that a person may be sterilized by appropriate means upon his request and upon the advice of a licensed physician. No special requirements are set forth in the Oregon statute.

Eighteen states and the District of Columbia have authorized the establishment of publicly-sponsored family planning programs (see Summary and Analy-

sis of State Laws Relating to Contraception). In two of these, Colorado¹² and Tennessee,¹³ the family planning act specifically provides that voluntary sterilization is an accepted contraceptive procedure, and requires that it be provided to anyone 18 years of age or older who requests it (dependent on the availability of funds to implement the program). The West Virginia statute,¹⁴ on the other hand, declares sterilization to be a nonapproved method. In the other 15 states and the District of Columbia it is not clear from the statutes whether "family planning" or "birth control services" include voluntary sterilization. (While Georgia and Oregon have special statutes authorizing voluntary sterilization, this does not necessarily mean it is included as part of the family planning program of the state.) However, the state health and/or welfare departments of 11 of these 15 states (Alaska, Georgia, Hawaii, Illinois, Iowa, Kansas, Michigan, Ohio, Oklahoma, Oregon, and Wyoming) and the District of Columbia have policies requiring or authorizing the referral for and/or purchase of voluntary sterilization for persons who wish it for purposes of family planning or birth control.

In one other of these states with affirmative family planning laws—California—is found the only judicial opinion on the question of whether family planning services include voluntary sterilization. In the leading California case of *Jessin v. County of Shasta*,¹⁵ the trial Court construed the California Administrative Code,¹⁶ as meaning that "voluntary non-therapeutic surgical sterilization operations, when requested, are basic and appropriate services in the field of family planning within the meaning of Section 1276 of the Administrative Code of the State of California." The trial court also held that it was "the duty of Shasta County to perform such operations when requested by persons entitled to receive the public health services of Shasta County." On appeal, the quoted language was deleted from the judgment, not because the appellate court disagreed with it, but because it was not in controversy and the court ruled that proper consideration was not given to it in the trial.

Thus, in at least 14 of the states which have laws authorizing or mandating the establishment of family planning programs (all except Louisiana, Nevada, New York and West Virginia) voluntary sterilization appears to be included among the contraceptive methods authorized in these programs; and only one of these states—West Virginia—excludes voluntary sterilization from its official family planning program.

Three states—Kansas, New Jersey and New Mexico—have statutes which, by implication, make clear that voluntary sterilization is legal in those states. The Kansas¹⁷ and New Jersey¹⁸ statutes provide that hospitals cannot be required to permit sterili-

zation procedures to be performed there. (These are similar to provisions in the Colorado,¹⁹ Georgia,²⁰ and Tennessee²¹ statutes. Although worded differently, all five statutes are designed to ensure that hospitals and doctors will not be required to perform or permit surgery when their refusal to do so is based on religious or conscientious objection.)

New Mexico has a statute providing that if a woman has been abandoned by her spouse, the spouse's consent will not be required for "voluntary medical sterilization."²² New Mexico also has a statute prohibiting a hospital and medical staff from setting up special qualifications for the performance of sterilization operations "which are not imposed on individuals seeking other types of operations in the hospital."²³ (Colorado has a similar statute.²⁴) This type of law, while not barring a hospital or doctor from refusing to permit or perform voluntary sterilization operations, is directed against institutional barriers to voluntary sterilization such as age-parity formulas (discussed below under Judicial Decisions Authorizing Voluntary Sterilization.)

Recently enacted statutes in California²⁵ and Tennessee²⁶ provide that no contract of insurance covering sterilization procedures may be entered into which imposes any restriction of coverage based upon the insured's reason for requesting sterilization.

As stated above, many states have "compulsory sterilization laws" which provide for the sterilization of mental incompetents (and, in some cases habitual criminals and epileptics). All of these laws establish elaborate procedures which must be followed in every case. Ten of the compulsory sterilization statutes contain provisions similar to Arizona's, which reads:

Nothing in this article shall be construed to prevent medical or surgical treatment based on sound therapeutic reasons of any person in the state by a physician or surgeon licensed by the state, which may incidentally involve nullification or destruction of reproductive functions.²⁷

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed on a person who is otherwise subject to the provisions of the compulsory sterilization law (i.e., a mental incompetent), the procedures prescribed in the compulsory sterilization law need not be followed although the operation may result in sterilization of the patient. By necessary implication these clauses establish the legality of voluntary sterilization performed for medical reasons on *any person*. The clauses are sometimes referred to as "savings clauses" because when there is a medical necessity for the sterilization they dispense with the procedural requirements for persons to whom the compulsory sterilization statutes would otherwise apply.

It is clear, however, that these "savings clauses" do not limit to medical necessity the permissible grounds of voluntary sterilization for persons not

subject to the compulsory statutes. Thus, although such clauses are found in the compulsory sterilization laws of Georgia, North Carolina and Virginia, those states specifically authorize by statute voluntary sterilization for any reason. Other states which have substantially similar "savings clauses" are Indiana, Mississippi, Montana, New Hampshire, Oklahoma and Utah (Utah also has the statute referred to above which may be read as permitting voluntary sterilization for reasons of medical necessity only—see discussion above and footnote 5).²⁸

Two states—South Carolina and West Virginia—have compulsory sterilization laws containing somewhat differently worded "savings clauses," which appear, however, to have the same legal effect as those in the ten states listed above.²⁹

Arkansas' compulsory sterilization law contains a "savings clause" so worded that it clearly authorizes voluntary sterilization for *any* reason.³⁰

Judicial Decisions Authorizing Voluntary Sterilization

We have found no reported case of an attempted criminal prosecution of a physician who sterilized a consenting patient.

The judicial decisions on the subject of voluntary sterilization of adults fall into two categories. First are cases in which the plaintiffs seek to compel a hospital or governmental body to perform or permit the performance of voluntary sterilization. Second are cases in which the plaintiffs seek damages for the allegedly negligent performance of voluntary sterilization procedures, resulting in unwanted pregnancies.

Suits Demanding Voluntary Sterilization

Probably the leading American case on the subject of voluntary sterilization is the California decision in *Jessin v. County of Shasta*.³¹ The plaintiffs, husband and wife, alleged that they were unable to provide medical care and health services for themselves and were eligible to receive such services from the appropriate county public health agency. They contended that as they were already the parents of as many minor children as they could adequately care for and support, the county was required by law to furnish them with surgical sterilization. The county refused to provide the services on the stated belief that the rendering of such services would be unlawful.

The county's argument was rejected by the trial court and by an intermediate appellate court. The appellate court said:

California has no public policy prohibiting consensual sterilization operations, and . . . non-therapeutic surgical sterilization operations are legal in this state where competent consent has been given.³²

As stated above (under Statutes Authorizing Voluntary Sterilization), the appellate court did not rule on the question of whether voluntary sterilization was a health service which the county was *obligated* to provide.

Often, persons seeking voluntary sterilization cannot obtain it because of institutional barriers such as hospital rules regarding eligibility. Many hospitals have adopted an "age-parity formula" pursuant to which a woman's age multiplied by the number of children she already has must equal an arbitrarily selected number (such as 100 or 130) before she will be allowed to be sterilized. Other hospitals simply refuse to perform voluntary sterilization procedures except for reasons of 'medical necessity.' We have seen (above, under Statutes Authorizing Voluntary Sterilization) that some states, by statute, protect a hospital's or physician's right to refuse to perform sterilizations. Even in the absence of a statute, a hospital which is entirely supported by *private* funds may have a constitutional right to choose which operations to permit. Recently, however, a number of individuals have successfully challenged the right of hospitals which receive *public funds* to set up rules restricting voluntary sterilization. The ground for these challenges is that such hospitals are "affected with state action" (i.e., acting in behalf of the state) and, therefore, may not arbitrarily discriminate against a patient who seeks to be sterilized.

Thus, in *McCabe v. Nassau County Medical Center*,³³ Mrs. Linda McCabe sought an order compelling a public hospital and its officials to sterilize her, as well as damages for their refusal to do so. The refusal was based on an age-parity formula under which Mrs. McCabe was required by the hospital to have five children before she could be sterilized. (She was actually 25 years old and had four small children.) Mrs. McCabe alleged that she could not afford to go to a private hospital for the operation. After the suit was commenced, the hospital reversed its position and performed the sterilization. The lower court thereupon dismissed the action as "moot and academic."

The United States Court of Appeals for the Second Circuit (New York and Connecticut) reversed the lower court's dismissal of the action. The Court of Appeals held that Mrs. McCabe had stated a valid cause of action for damages.

In a similar New York suit, a hospital permitted a sterilization procedure to be performed after a lower federal court ruled that it would order the hospital to permit performance of the procedure if it failed to do so voluntarily within the time fixed by the court.³⁴

The United States District Court for the District of Oregon recently handed down a decision in the case of *Chrisman v. Sisters of St. Joseph of Newark*.³⁵

Mrs. Barbara Ann Chrisman, having decided, for socioeconomic reasons, to bear no more children following the termination of her then current pregnancy, requested that the hospital allow her doctor to perform a tubal ligation during her forthcoming maternity hospitalization. The hospital refused. Mrs. Chrisman thereupon sued for damages and for an order compelling the hospital to permit the surgery. During pretrial proceedings, she obtained the desired sterilization at another hospital. The defendants moved for summary judgment, claiming among other things that the action had become moot.

The court refused to give judgment for the defendants, holding that Mrs. Chrisman still had a claim for damages and that she presented in good faith a question of substantial public interest.

The court held that the hospital, which receives substantial funds under the Hill-Burton Act, is "affected with state action, and therefore cannot engage in racial or other arbitrary forms of discrimination when deciding which patients and physicians to admit to the hospital."

The court ruled that a trial was necessary to determine whether the hospital was truthful in asserting that the refusal to allow sterilization was based on purely medical considerations. Mrs. Chrisman contended that, actually, the hospital's committee on sterilization made a value choice involving moral and religious considerations. The minutes of the committee disclosed that, in each case when sterilization operations were not recommended, the patient desired the operation for socioeconomic rather than medical reasons. The court stated that "the meaning of these social and economic considerations involves a question of fact." At the time this report was written the trial was still pending. Similar suits are pending in at least two other jurisdictions.³⁶

As stated above (under Statutes Authorizing Voluntary Sterilization), two states (Colorado and New Mexico) have statutes forbidding hospitals from imposing any special requirements as a prerequisite for sterilization operations. These statutes are directed against hospital practices such as the age-parity formula plaintiffs objected to in the *McCabe* case, discussed above. They do *not* necessarily prevent the type of hospital action plaintiffs complained about in the *Chrisman* case, i.e., a refusal to perform *any* nontherapeutic sterilization. Colorado, as we have seen has another statute specifically permitting hospitals and doctors to refuse to participate in practices which violate their religious beliefs; there are similar laws in Kansas, New Jersey, Georgia and Tennessee.

Negligent Sterilization Cases

There are judicial decisions in at least 10 states in suits against doctors for allegedly negligent sterilizations resulting in unwanted pregnancies. In all the

cases, the court either explicitly rejected the argument that voluntary sterilization was against the public policy of the state, or (where no one raised the question) assumed that it was legal. The issue around which most controversy has centered is not the legality of voluntary sterilization, now generally conceded, but the proper measure of damages, if any, for the birth of a healthy but unwanted child. As will be seen from the following review of the case law, judicial thought on this subject has moved from an early view that no damages could be recovered to some recent cases indicating that damages should include the cost of raising and educating the unplanned child.

The earliest and best known case is the Minnesota case of *Christensen v. Thornby*, decided in 1934.³⁷ That was a suit based on the failure of a vasectomy performed on the husband for reasons of the wife's health. The defendant doctor argued that there should be no recovery because voluntary sterilization was against public policy. The Minnesota Supreme Court rejected this argument, pointing out that, except for the few states which at that time had statutes prohibiting voluntary sterilization,³⁸ they had found no judicial or legislative announcement of public policy against voluntary sterilization.

The court also rejected the argument, which was sometimes raised in the early cases, that voluntary sterilization constituted "mayhem," an old common law crime which consisted of an injury making the victim "unable to fight for the King,"³⁹ pointing out in its opinion that voluntary sterilization "does not impair, but frequently improves the health and vigor of the patient."

However, damages to compensate for expenses arising from the birth of the child were denied in this case, on the ground that the operation was done for therapeutic purposes, i.e., to protect the mother's physical health, and not to prevent the birth of a child.

The question of damages for the birth of a healthy child following the failure of a voluntary sterilization operation came up again in *Shaheen v. Knight*,⁴⁰ a case decided in 1957 by a Pennsylvania lower court. Here the issue was presented squarely, because the voluntary sterilization was performed for contraceptive rather than medical reasons. The court held that the contract between the doctor and patient to sterilize the patient was not void as against public policy. Nevertheless, the plaintiff was not permitted to recover on the ground that it would be inequitable for him to have the "fun, joy and affection . . . of rearing and educating" the child while the doctor supported it.

Prior to 1967, there were judicial decisions also in New Jersey,⁴¹ North Dakota,⁴² the state of Washington,⁴³ Illinois,⁴⁴ and West Virginia⁴⁵ recognizing a right of recovery for negligent sterilization, but

regarding as elements of damages only the pain and suffering, mental and physical, caused by the unwanted pregnancy, plus the expenses of the pregnancy and loss of the wife's services during her confinement.

In 1967, a California intermediate appellate court in the case of *Custodio v. Bauer*⁴⁶ went further by suggesting that the children already born might be able to recover for the loss of support and affection suffered if their mother were compelled to spread herself among a larger group as a result of negligent sterilization "should such change in family status be measurable economically."

The changed attitude adumbrated in *Custodio* was more fully developed in recent cases in Florida⁴⁷ and Delaware⁴⁸ which accepted the principle that damages may be recovered for the birth of an unplanned, healthy child. (This principle was also recently endorsed in a Michigan case brought against a pharmacist who negligently filled a prescription for birth control pills. The court held that the cost of rearing the unwanted child born as a result of the pharmacist's negligence was a proper element of damages.⁴⁹)

Attorneys General's Opinions

Attorneys General's opinions in Iowa,⁵⁰ Kentucky,⁵¹ Michigan,⁵² Mississippi,⁵³ Missouri,⁵⁴ New York,⁵⁵ South Carolina,⁵⁶ and Wisconsin⁵⁷ recognize the legality of voluntary sterilization for contraceptive purposes in those states.

The Missouri and Wisconsin opinions in particular discuss the applicability of "mayhem" statutes in those states and conclude that these statutes can have no possible relevance to a surgical procedure consented to voluntarily. In this respect, of course, voluntary sterilization is no different from any other surgical procedure to which the patient knowingly consents.

Minors

Generally minors do not seek voluntary sterilization, which is a permanent means of birth control, unless a pregnancy would endanger their health, or they are carriers of a heritable disease. For those who do wish it, the law is in general the same as that applicable to any other surgical procedure performed on a minor.

However, of the statutes which specifically authorize voluntary sterilization, all except the Oregon statute prescribe a minimum age. In Georgia the person must be 21 or married. In North Carolina he or she must be 18 or married unless "the juvenile court of the county where the minor resides, upon petition of the parent or parents, if living, or the guardian or next friend of the minor, shall determine that the operation is in the best interest of such minor and shall enter an order authorizing the

physician or surgeon to perform such operation." In Tennessee and Colorado the individual must be 18 or married, unless (in Colorado) he or she has the consent of parent or guardian.

The Virginia statute says that the person sterilized must be 21 or older. However, the Virginia Attorney General, interpreting the new Virginia statute enabling minors to consent to "medical or health services required in case of birth control," has stated that sterilization is a means of birth control and that minors can therefore consent to be sterilized for contraceptive purposes without the consent of a parent or guardian.⁵⁸

Although rendered moot by a new Virginia law effective July 1, 1972 (see Virginia state profile), this opinion raises the question whether voluntary sterilization is included as a means of birth control under a) statutes enabling minors to consent to birth control services; and b) statutes authorizing or approving publicly sponsored family planning programs (some of which have been interpreted by administrative departments as authorizing services to minors without parental consent).

Sometimes the statute is specific on this issue. For example, the Maryland statute enabling minors to consent to birth control services and the Georgia and Kentucky medical consent laws giving certain categories of minors the right to consent to medical services in general specifically exclude sterilization. On the other hand, both Colorado and Tennessee in their family planning acts declare sterilization to be an approved contraceptive procedure. (Both Colorado and Tennessee, however, as stated above, have statutory provisions with regard to the minimum age for sterilization).

In the absence of a relevant statute, the general rules applicable to medical and surgical treatment of minors would seem to apply to voluntary sterilization. The leading case involving consent of a minor to voluntary sterilization is the 1967 Washington case of *Smith v. Seibly*,⁵⁹ where the court, holding that a married minor could validly consent to a vasectomy, couched its opinion in terms of the intelligence and maturity of the minor and his ability to understand the nature and consequences of the procedure. However, since voluntary sterilization is usually an irreversible and, in the case of a woman, may be a serious surgical procedure, in the absence of a statute many courts in applying the "mature minor doctrine"⁶⁰ might be reluctant to hold that a minor could give effective consent to it, although the same court might well find that a minor could effectively consent to contraceptive services, which are of temporary effect and do not involve surgery.

Conclusion

Voluntary sterilization may be performed by a physician on the request of a competent individual in all

states. In Utah, where the law could be interpreted to restrict voluntary sterilizations to those performed for reasons of medical necessity, a lower court has ruled that this restriction applies only to inmates of state institutions. (The case has been appealed.) Forty-four states, the District of Columbia and the Virgin Islands have specifically affirmed the legality of voluntary sterilization by statute, judicial decision, Attorneys General's opinion and/or policies of state health and welfare departments. Most states have no special requirements regarding procedures for voluntary sterilizations other than that they be performed by licensed physicians, and (for women) in licensed hospitals. In several states age and parity requirements for sterilization, which used to be quite common, have been prohibited by statute or judicial decision. A few states require spousal consent, a waiting period, and/or detailed explanation of the operation. Some others relieve hospitals or physicians from performing sterilization operations which violate their conscience. Increasingly, however—as reflected both in statute and judicial decisions—voluntary sterilization is coming to be regarded as a right which may not be denied, at least by hospitals or physicians which receive public funds.

Footnotes to "State Laws Relating to Sterilization"

1. The term "elective sterilization" has been suggested for voluntary sterilization which is performed for contraceptive rather than other medical reasons. See Note, *Elective Sterilization*, 113 U. Pa. L. Rev. 415 (1965).
2. American Jurisprudence Proof of Facts Ann. (1968), Vol. 21, p. 255 et seq.
3. Ibid.
4. See *United States v. Vuitch*, 91 S. Ct. 1294, 28 L. Ed. 2d 601 (1971).
5. Utah Code Ann. § 64-10-12 (1968).
6. *Parker, et al v. Rampton, et al*, Dist. Ct. Salt Lake County, Utah, Civil Judgment #195446, April 8, 1971.
7. Conn. Gen. Stat. Rev. § 53-33 (repealed effective October 1, 1971); Kan. Gen. Stat. Ann. § 76-155.
8. Ga. Code Ann. §§ 84-931 to 935 (Supp. 1970).
9. N.C. Gen. Stat. §§ 90-271 to 275 (1965 and Cum Supp. 1971).
10. Va. Code Ann. §§ 32-423, 32-425, 32-426, 32-427 (1969).
11. Ore. Rev. Stat. § 435.305 (1969).
12. Colo. Rev. Stat. § 66-32-2 (1971).
13. Senate Bill No. 871, Ch. 400, Pub. Acts of 1971.
14. W. Va. Code Ann. § 16-2 B-2 (1970 Supp.).
15. 274 Cal. App. 2d 737, 79 Cal. Repr. 359 (Ct. App. 3d D. 1969).
16. To be distinguished from the California Welfare & Institutions Code, § 10053.2 of which establishes California's family planning program for all former, current and potential public assistance recipients of childbearing age. Section 10053.2, enacted as part of the Welfare Reform Act of 1971, is more fully discussed in the California profile under Contraception. It is not clear whether "family planning services" under § 10053.2 include voluntary sterilization.
17. House Bill No. 1307, Ch. 206 (1971).
18. N.J. Stat. Ann. § 30:11-9 (1964).
19. Colo. Rev. Stat. § 66-32-2 (1971).
20. Ga. Code Ann. § 84-935.2 (Supp. 1970).
21. Senate Bill No. 871, Ch. 400, Pub. Acts of 1971.

22. N.M. Stat. Ann. § 12-3-43 (Supp. 1970) .
23. N.M. Stat. Ann. § 12-3-44 (Supp. 1970) .
24. Colo. Rev. Stat. § 66-32-2 (1971) .
25. Calif. Ins. Code §§ 10120, 10121, and 11512.1 (Supp. 1971) ; Calif. Gov't. Code § 12532.7 (Supp. 1971) .
26. Senate Bill No. 871, Ch. 400, Pub. Acts of 1971.
27. Ariz. Rev. Stat. § 36-540 (1966) .
28. For citations, see individual state profiles under Voluntary Sterilization.
29. These laws are quoted in the South Carolina and West Virginia state profiles.
30. Ark. Rev. Stat. Ann. § 59-501 (m) (1971) (quoted in Arkansas profile) .
31. *Supra* note 15.
32. 274 Cal. App. 2d at 744, 79 Cal. Rptr. at 366.
33. Docket No. 71-1371 (U.S. Ct. Ap. 2d Cir. 1971) .
34. *Caffarelli v. Peekskill Community Hospital*, Docket No. 71-3617 (U.S.D. Ct. S.D. N.Y. 1971) .
35. Civ. No. 70-430 (U.S.D. Ct. D. Ore. 1971) .
36. See Association for Voluntary Sterilization Progress Report, January 19, 1972, p. 3—"Operation Lawsuit."
37. 192 Minn. 123, 255 N.W. 620 (1934) .
38. The Connecticut and Kansas statutes prohibiting voluntary sterilization have been repealed since the decision in *Christensen v. Thornby*. As stated above, the only state which now has a statute which may prohibit voluntary sterilization except for medical necessity is Utah.
39. See 4 Blackstone Commentaries 205-06 (7th Oxford Ed. 1775) .
40. 11 D & C 2d 41 (Lycoming County Ct. 1957) .
41. *West v. Underwood*, 132 N.J. L. 325, 40 A. 2d 610 (1945) .
42. *Milde v. Leigh*, 75 N.D. 418, 28 N.W. 2d 530 (1947) .
43. *Ball v. Mudge*, 64 Wash. 2d 247, 391 P. 2d 201 (1964) .
44. *Doerr v. Villate*, 74 Ill. App. 2d 332, 220 N.E. 2d 767 (1966) .
45. *Bishop v. Byrne*, 265 F. Supp. 460 (S.D. W.Va. 1967) .
46. 251 Cal. App. 2d 303, 59 Calif. Reprtr. 463 (Ct. Ap. 1st D. 1967) .
47. *Jackson v. Anderson*, 230 So. 2d 503 (1970) .
48. *Coleman v. Garrison*, 281 A. 2d 616 (Del. Super. Ct. 1971) .
49. *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W. 2d 511 (1971) .
50. 1932 Opin. Atty. Gen. Iowa 35.
51. Opin. Atty. Gen., Nov. 2, 1964.
52. Letter from Attorney General Frank J. Kelley to Harriet F. Pilpel, January 10, 1972.
53. Letter from Assistant Attorney General R. Hugo Newcomb, Sr. to Harriet F. Pilpel, Sept. 1, 1971.
54. Op. Atty. Gen. No. 393, Aug. 19, 1971.
55. Letter from Attorney General Louis J. Lefkowitz to Commissioner of Social Services George K. Wyman and Commissioner of Health Hollis S. Ingraham, Aug. 21, 1967.
56. 1958-59 Opin. Atty. Gen. 224, 226.
57. Letter from Attorney General Bronson C. La Follette to Thomas W. Tormey, Jr., M.D., Nov. 25, 1968.
58. See Virginia profile—Sterilization—Minors.
59. See Washington state profile under Contraception—Contraceptive Services to Minors and Sterilization—Minors.
60. For a discussion of the "mature minor doctrine," see the General Summary and Analysis of Laws Relating to Contraceptive Services to Minors.

Summary and Analysis of State Laws Relating to Contraceptive Services to Minors

General Status of Laws Relating to Contraceptive Services to Minors

In the last few years there has been a strong trend to pass liberalizing and clarifying laws giving minors access to effective birth control services on their own consent and initiative. This parallels the general trend for laws on contraceptives (described in *Laws Relating to Contraception*, above) and the recent wave of laws (adopted by 47 states) permitting minors to obtain examination and treatment for venereal disease without parental consent.

No state expressly prohibits the provision of contraceptives to minors. (New York restricts pharmacists from dispensing contraceptives without a physician's prescription to persons younger than 16; but this section does not apply to doctors.) To the extent contraception for minors raises legal questions, it is primarily in the area of parental consent.

We know of no case in which either a doctor or a layman has been successfully prosecuted under any criminal statute for providing contraceptive information or services to a minor or has been held liable for damages for providing contraception to a minor without parental consent.

Under the old common law rule (i.e., the law developed in court decisions over the course of centuries, first in England and then in the United States), the consent of a parent or guardian was considered necessary before a physician could treat a minor, and physical contact by a physician with a minor without parental consent could constitute assault and battery¹ or malpractice² and make the physician liable for damages in a civil suit. However, these rules were always subject to a variety of exceptions, such as emergency treatment and treatment of emancipated minors.

It is a basic principle of the general common law governing the physician-patient relationship that the patient must consent to medical or surgical treatment. Certain classes of people, such as the insane, the mentally deficient and minors in general have been regarded as incompetent to give legally binding consent. With regard to the mentally retarded or insane, it is understandable why they are deemed to lack the capacity to understand what it is they

are consenting to. This is true also of very young children; it is doubtful if it applies to most teenagers. As stated by Justice William O. Douglas, "[T]here is substantial agreement among child psychologists and sociologists that the moral and intellectual maturity of the fourteen-year-old approaches that of the adult."³ The common law by and large, however, did not in early days distinguish between the infant and the mature teenager, lumping them together as "minors" and treating them, in general, as the "property" of their parents, who could make any and all decisions affecting them.

Increasingly today, the federal government and the states have recognized the rights of mature minors to make their own decisions about their lives generally, and about their medical care in particular. Thus, since passage of the Twenty-Sixth Amendment granting the vote to 18-year-olds, there has been a nationwide trend to reduce the age of majority to 18. Fourteen states have already done so. What is more, the old common law requirement of parental consent for medical treatment of minors, insofar as it applies to sex-related health services including birth control, VD treatment, and treatment for pregnancy, is being rapidly abrogated or modified both by the courts and the state legislatures, with the result that minors of any age or above a stated age often are able to consent to their own care for all or some of these services. By 1972, in at least two-thirds of the states, females who had reached the age of 18 clearly were entitled to consent to their own birth control care;⁴ and about one-third of these states they could so consent at considerably lower ages, or with no age restriction at all.⁵

The courts and state legislatures have gotten away from the old common law rule through the exception for emergency medical treatment of minors, through the doctrine of the emancipated minor and by new exceptions for the mature minor and the abused and neglected minor. In addition, numerous statutes have been enacted giving broad categories of minors the right to consent to medical services in general and to contraceptive services in particular.

Emergency Treatment of Minors

Courts throughout the country have held that, when confronted with an emergency which endangers the

life or health of a minor, a physician need not wait to obtain parental consent before commencing treatment.⁶ Many courts have held that there must be immediate danger to the patient's life or health (sometimes defined to include mental health), and some have said that the burden of proving that there was an emergency is on the physician.⁷

The emergency exception, in addition to its widespread acceptance by the courts, has been codified (i.e., embodied in laws passed by the legislature) in Alabama,⁸ Georgia,⁹ Illinois,¹⁰ Kentucky,¹¹ Maryland,¹² Massachusetts,¹³ Minnesota,¹⁴ Mississippi,¹⁵ New York,¹⁶ North Carolina,¹⁷ Pennsylvania,¹⁸ and Rhode Island,¹⁹ all of which have statutes authorizing a physician to treat a minor without parental consent where immediate treatment is required. In addition, Arizona, Nevada and New Mexico have emergency statutes whereby persons in loco parentis may consent for minors' care in emergencies.²⁰

Contraceptive consultation and service provided to sexually active minors might be construed as falling into the category of emergency treatment where failure to provide such consultation and service is likely to result in a pregnancy which could endanger the life and health of the minor and the life and health of any child who may be born. Support for this argument is to be found in the facts relating to well-known medical risks of pregnancy faced by teenage girls. These include the risk to the pregnant girl caused by greatly increased frequency of anemia, hypertension, eclampsia and maternal mortality as well as the risk of stillbirth, prematurity, perinatal and infant mortality and brain injury to the child born.²¹ That child is also more likely, if it survives, to be subjected by its youthful mother to general neglect, or even physical abuse.²² (In addition there are, of course, the obvious social consequences: illegitimacy, precipitate marriage, school-dropout, marital instability, poverty and dependency.) There is no case law on this question, since no cases appear thus far to have arisen challenging medical contraceptive treatment of minors without parental consent even though such services are in fact being rendered in many states where they have not been provided for by specific statute.

The Emancipated Minor

The legislatures of at least 21 states²³ have declared that a minor who is emancipated and/or married can effectively consent to his or her own medical care. Courts in several states where there is no specific statute have held that emancipated minors can effectively consent to their own medical treatment.²⁴ Since emancipation is viewed by the courts as an extinguishment of parental rights and duties, there can be little doubt that, even in the absence of a statute or judicial precedent, most courts would hold

that a completely emancipated minor can consent to his or her own medical treatment.

The relationship of parent and child gives rise to certain parental rights and duties, such as the parent's right to control the child and make decisions for it as well as the parent's right to the child's earnings and the parent's obligation to support the child. The term "emancipation" is commonly used to refer to the partial or complete extinguishment of these parental rights and duties but not necessarily the removal of all the legal disabilities of childhood (such as the child's inability to enter into binding contracts or to own property or bring a lawsuit in his or her own name.²⁵)

"The emancipation of a child may be complete or partial. A minor may be emancipated for some purposes and not for others and similarly a parent may be freed of some of his obligations and divested of some of his rights yet not freed and divested of others . . ." ²⁶ "While it is often said emancipation cannot be accomplished by an act of the child alone, this is not always true. Marriage and entering into military service have been held to be acts of self-emancipation."²⁷

Most often, marriage is the event that emancipates a minor. In some states, statutes provide that minority ends upon marriage,²⁸ but even in the absence of such statutes courts generally hold that a minor is emancipated by marriage.²⁹

Since marriage is regulated by statute, the language of the statute will generally determine what constitutes a valid marriage. While the subject of marriage is outside the scope of this study, the following observations should help explain the meaning of "emancipation":

In U.S. jurisdictions, before the enactment of statutes covering the subject, the age at which a person had capacity to contract marriage was 14 years for males and 12 years for females.³⁰ Most states have enacted statutes substantially increasing the minimum common law age requirement.³¹

This common law (i.e., judge-made) rule was that the marriage of a person younger than age seven was absolutely void and a nullity, and that the marriage of one over the age of seven, but under the age of consent—14 for a male and 12 for a female—was "voidable," i.e., valid for all civil purposes until annulled by a judicial decree.³² While the general view today is that marriages of persons under the statutory age of consent but over the age of seven are not void but only voidable, some statutes expressly declare some such marriages to be void.³³ However, while minors who have reached the statutory age of consent may be lawfully married, many state statutes still require them to obtain the consent of one or both parents or of their guardian before they can obtain a marriage license. Generally speaking, a

marriage entered into by persons who have attained the statutory age of consent is held valid even though parental consent has not been obtained, unless a statute specifically provides to the contrary.³⁴

In some states, therefore, a minor who has reached the statutory age of consent to marriage can, by marrying, emancipate himself.³⁵ Some courts have held that a marriage entered into against the parents' wishes will emancipate a daughter who is under the statutory age of consent, provided that she is older than 12, the common law age of consent.³⁶

A minor who enlists in the armed forces of the state or nation is thereby emancipated for at least as long as his military service continues.³⁷ A minor will generally be deemed emancipated if he lives apart from his parents, is self-supporting and generally controls his own life.³⁸ A minor living apart from his parents, with their consent, may be emancipated, even though they still support him.³⁹ Some case law indicates that a minor who still lives in the parental home may be emancipated if he or she works and keeps all or part of his or her earnings.⁴⁰ The job must, however, be a real one; although a minor regularly employed by a parent in the parental business may be emancipated thereby,⁴¹ the fact that he or she performs household chores or renders occasional assistance in the family business in exchange for a small allowance is not usually held to emancipate the minor.⁴² A minor may be emancipated by judicial decree and some states have a special procedure whereby this can be done.⁴³ A minor can also be emancipated by failure of the parents to meet their legal responsibilities.⁴⁴

Of the 21 states which provide by statute that an emancipated and/or married minor may effectively consent to medical care, at least five—Alabama, California, Colorado, Minnesota and Pennsylvania—define emancipation in the statute and, in some instances, the statutory definition appears broader than the court-made common law rule (e.g., California, Colorado and Minnesota—see “Statutes Relating to Medical Care of Minors,” below).⁴⁵

It is generally held that the burden of proving that a minor is emancipated is on the person asserting emancipation.⁴⁶ Some states, however, have statutory provisions protecting from any liability a physician or other person who in good faith relies on the representation of a minor purporting to consent to medical treatment that he is emancipated.⁴⁷

Partial Emancipation

Whether or not a court finds that a minor is emancipated often depends on the purpose for which emancipation is asserted; courts frequently speak of “partial emancipation” or emancipation for a particular purpose. For example, courts have found minors “partially emancipated” for the purpose of keeping their own earnings,⁴⁸ of claiming Work-

men's Compensation,⁴⁹ of owning cattle,⁵⁰ and in order to determine a settlement for poor-relief purposes.⁵¹

A New York court held that a minor who was not emancipated for the purpose of altering her property rights *was* emancipated for the purpose of consenting to medical services.⁵² A sexually active minor might be held emancipated for the limited purpose of consenting to his or her own contraceptive services, although, as yet, the issue of contraceptive medical service as opposed to medical service in general has not been presented for judicial determination.

The Mature Minor

Some state courts have declared the existence of a relatively recent exception to the common law rule which has become known as the “mature minor rule.” In essence, it provides that a minor effectively can consent to medical treatment for himself if he understands the nature of the treatment and it is for his benefit.⁵³ This rule has been incorporated in a statute in Mississippi, where the law provides that an unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment may effectively consent to it.⁵⁴

The “mature minor rule” has also been endorsed in effect by the New Hampshire legislature. A 1972 New Hampshire statute which enables minors aged 12 or older to consent to treatment for drug dependency provides:

Nothing contained herein shall be construed to mean that any minor of sound mind is legally incapable of consenting to medical treatment provided that such minor is of sufficient maturity to understand the nature of such treatment and the consequences thereof.⁵⁵

In a 1970 Kansas case, *Younts v. St. Francis Hospital & School of Nursing, Inc.*,⁵⁶ a mother sued on behalf of her 17-year-old daughter for an allegedly unauthorized surgical procedure. The daughter had been visiting her mother in the hospital when a nurse slammed a door on her finger. The resident surgeon in the emergency room operated on the girl's finger without obtaining parental consent. The Kansas Supreme Court held that no damages could be recovered. Noting that the girl was 17 years old and intelligent and capable for her age, and that the surgery was minor, the court applied the “mature minor doctrine”; it held that a minor old enough and intelligent enough to understand the nature and consequences of the proposed treatment effectively could consent to the treatment if it was for her benefit.

Similar decisions were reached by an Ohio court with respect to an 18-year-old girl who consented to plastic surgery on her nose,⁵⁷ and by a Michigan court with respect to a 17-year-old boy who consented

to removal of a tumor.⁵⁸ The majority of judges in the Ohio case rejected the view that the validity of consent to medical care depends on the consenting party's capacity to contract. Instead, the judges used analogies from the fields of criminal and tort law, such as the age at which a person can be held responsible for criminal conduct and can "assume the risk" in a negligence case and the age at which a girl's consent to sexual intercourse precludes it from being considered as rape.

A 1967 Washington case, *Smith v. Seibly*,⁵⁹ which held that an 18-year-old married minor could consent to a vasectomy, couched its decision in terms of the intelligence and maturity of the minor and his ability to understand the doctor's explanation of the nature and consequences of the surgery.

The Neglected Minor

Almost all states now have statutes dealing with neglected and/or abused children; some of these statutes provide specifically that the court may order medical care for such minors.⁶⁰ In a number of cases, courts have stepped in to sanction medical services for neglected minors without parental consent.⁶¹ While in earlier periods, the cases usually involved emergency treatment, such as blood transfusions, the more recent trend is to broaden the area in which the court will act. Thus, with reference to a statute giving the New York Family Court power to order medical care for a neglected child without parental consent, that court recently held that the court's power was not limited to "drastic situations" or those which constitute a "present emergency"; rather, the court will order medical or surgical treatment for a child even over parental objections, if, in the court's judgment, the health, safety or welfare of the child requires it.⁶²

Statutes Giving Minors the Right to Consent to Contraceptive Services

At least nine states have enacted statutes specifically authorizing physicians to provide birth control services without parental consent either to all minors or to broad categories of minors. These include California,⁶³ Colorado,⁶⁴ Georgia,⁶⁵ Illinois,⁶⁶ Kentucky,⁶⁷ Maryland,⁶⁸ Oregon,⁶⁹ Tennessee,⁷⁰ and Virginia.⁷¹ A similar rule has been adopted in the District of Columbia.⁷²

The Maryland statute, enacted in 1971, gives all minors the same capacity to consent to medical treatment as adults if the minor seeks treatment or advice concerning venereal disease, pregnancy or contraception not amounting to sterilization. The Virginia statute, also enacted in 1971, provides that while 18-year-olds may consent to all medical care, minors younger than 18 years may effectively consent to medical or health services required in connection with birth control, pregnancy and family planning.

The 1972 Georgia and Kentucky statutes enable minors of any age to consent to contraceptive services and treatment for pregnancy and childbirth, but not abortion or sterilization; the Georgia provision is limited to females.

Colorado and Tennessee have both provided, as part of their comprehensive family planning acts of 1971, that birth control services "may be furnished by physicians to any minor who is pregnant, or a parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of [the] state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies or information."

In 1969, Illinois adopted a statute authorizing licensed physicians to provide birth control services to minors in the general categories listed above for Colorado and Tennessee (except for minors "who request and are in need of" information or services). In addition, Illinois authorizes birth control services without parental consent for minors "as to whom the failure to provide such services would create a serious health hazard."

In Oregon, the statute states that "any physician may provide birth control information and services to any person without regard to the age of such person and a minor 15 years of age or older may give consent to medical or surgical diagnosis or treatment by a [licensed] physician . . . without the consent of a parent or guardian."

California's Welfare Reform Act of 1971 provides that family planning services shall be *offered* to all former, current or potential public assistance recipients of childbearing age (defined in the statute as age 15-44 inclusive) without regard to marital status, age or parenthood, and shall be *provided* to those former, current or potential recipients wishing such services. The statute specifically provides that the furnishing of family planning services shall not require the consent of anyone other than the person who is to receive them.

Comprehensive Family Planning Acts

As stated above, nine states and the District of Columbia have enacted laws specifically authorizing physicians to provide contraceptive services either to all minors or to broad categories of minors without parental consent.

At least nine other states (Alaska,⁷³ Kansas, Louisiana, Michigan, Nevada, New York, Oklahoma, West Virginia and Wyoming) have enacted laws authorizing publicly sponsored family planning programs which specifically permit, or do not expressly exclude, services to otherwise eligible minors (e.g., call for services to "any person"). In addition, Iowa and Ohio have family planning programs for wel-

fare mothers which might reach minor unwed mothers living at home. The health or welfare departments in seven of these 11 states furnish contraceptive services to minors without requiring parental consent.⁷⁴

Legislation Reducing the Age of Consent

The age at which a minor can consent to medical care is affected by statutes which reduce the age of majority. There is a strong nationwide trend, as shown by the adoption of the Twenty-sixth Amendment to the United States Constitution allowing 18-year-olds to vote, toward reducing the age at which a person can undertake various activities below the traditional age of 21. Of course, the age of majority has never been uniform in all states; some states, such as Arkansas,⁷⁵ Idaho,⁷⁶ Nevada,⁷⁷ Oklahoma,⁷⁸ South Dakota,⁷⁹ and Utah,⁸⁰ have differentiated between males and females, providing by statute that females attain majority at 18 and males at 21.⁸¹

Statutes reducing the age of majority to 18 for both sexes and for all (or virtually all) purposes have been enacted in Arizona,⁸² Connecticut,⁸³ Kentucky,⁸⁴ Maine,⁸⁵ Michigan,⁸⁶ New Jersey,⁸⁷ New Mexico,⁸⁸ North Carolina,⁸⁹ North Dakota,⁹⁰ Tennessee,⁹¹ Vermont,⁹² West Virginia,⁹³ Wisconsin,⁹⁴ and Wyoming.⁹⁵ Alaska⁹⁶ and Montana⁹⁷ have lowered the age of majority to 19, and Hawaii⁹⁸ and Nebraska⁹⁹ to 20. In Delaware,¹⁰⁰ 19-year-olds and in Illinois¹⁰¹ and Oregon¹⁰² 18-year-olds may now enter into binding contracts. Washington has declared that all persons of 18 shall be deemed of full age for most purposes including consent to medical care.¹⁰³

In addition, the age at which a person can effectively consent to medical care specifically has been reduced by statute to 18 in Colorado,¹⁰⁴ Connecticut,¹⁰⁵ Georgia,¹⁰⁶ Illinois,¹⁰⁷ Maryland,¹⁰⁸ New Jersey,¹⁰⁹ New York,¹¹⁰ North Carolina,¹¹¹ Pennsylvania,¹¹² and Virginia,¹¹³ to 15 in Oregon,¹¹⁴ and (subject to certain conditions) California¹¹⁵ and Colorado¹¹⁶ and to 14 in Alabama.¹¹⁷

In Kansas, a 16-year-old may consent to medical care when no parent or guardian is available.¹¹⁸ And in Mississippi any "mature" minor may consent to his or her own medical care (see discussion of the "Mature Minor Rule," above).

Statutes Relating to Medical Care of Minors in General

At least 11 states—Alabama,¹¹⁹ California,¹²⁰ Colorado,¹²¹ Georgia,¹²² Illinois,¹²³ Kentucky,¹²⁴ Maryland,¹²⁵ Minnesota,¹²⁶ Mississippi,¹²⁷ North Carolina,¹²⁸ and Pennsylvania¹²⁹—have gone beyond reducing the age of consent for medical care, and have enacted comprehensive statutes regarding the medical treatment of minors. These statutes enable min-

ors affectively to consent to medical treatment in many situations, but the states differ in the specific situations covered.

All except California and Colorado have codified the common law exception for emergency treatment of minors; with Maryland giving a very broad definition of "emergency" (when delay in treatment would "adversely affect the life or health of the minor.")

Married minors can consent to medical care in all 11 states. With respect to minors who are emancipated, other than those who are married, the statutes vary. Mississippi and North Carolina simply provide that a minor who is emancipated may consent to medical care. In Kentucky, any emancipated minor or any minor who has contracted a lawful marriage or borne a child may consent. Other states, in effect, permit emancipated minors to consent and provide their own definition of "emancipated." In Maryland, the parent of a child may consent. In Alabama, anyone who has graduated from high school or is pregnant or has borne a child may consent. In Pennsylvania, anyone who is a high school graduate or has been pregnant may consent. California, Colorado and Minnesota authorize a minor who is "living separate and apart from his parents or legal guardian . . . and . . . managing his own financial affairs, regardless of the source of his income" to consent to medical treatment. (In California and in Colorado, however, the minor must also be 15 or older.) Minnesota, in addition, authorizes a minor who has borne a child to consent to medical services. As discussed above, Mississippi has also codified the "mature minor rule" by permitting an unemancipated minor "of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment" to consent.

In addition, all 11 states provide that minors can consent to medical treatment for venereal disease; nine of the states provide that minors can consent at any age, but in California and Illinois the minor must be 12 or older. (See discussion under Treatment of Minors for Venereal Disease, below.) Each of the comprehensive statutes, except for Colorado and North Carolina, provides that minors may consent to medical care related to pregnancy (see discussion under Treatment of Minors Related to Pregnancy, below).

As noted above, Colorado, Georgia, Illinois, Kentucky and Maryland specifically authorize minors to consent to contraceptive services; California has specifically dispensed with parental consent for contraceptive services to minors older than 15 who are former, current or potential recipients of public assistance, or who are living separate and apart from their parents and managing their own financial affairs.

Treatment of Minors for Venereal Disease

At least 47 states and the District of Columbia have enacted statutes providing that minors can consent to treatment of venereal disease.¹³⁰ (The Attorney General of a forty-eighth state, South Carolina, has stated that, in his opinion, treatment of minors without parental consent is permitted under a general statute in that state providing for treatment of venereal disease.)¹³¹

In the preamble to the New Jersey law,¹³² which was passed in 1968, the legislature stated its reasons for enacting this legislation:

. . . Since contraction of a venereal disease is subject to serious reproach within the family circle, the necessary parental consent to treatment may not be sought by the minor because of fear or embarrassment. Allowing the child to secure competent medical treatment and to consent thereto, without the necessity for either knowledge by or consent of the parent, would eliminate one of the major bars to his seeking and receiving treatment.

The threat to public health from venereal disease is of such gravity that the infected person should be treated as soon as diagnosed to protect his health and prevent the spread of the disease to others. In view of the danger posed and the increasing numbers of minors infected, it is essential that this highly vulnerable segment of our population be accorded greater freedom in securing prompt medical treatment.

More than half of the statutes enabling minors to consent to treatment for venereal disease have been enacted since 1968. Similar developments in the law giving all minors the right to consent to contraceptive services seem in process, particularly in the light of the recent statutes in many states and the endorsement of this position by the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the American Academy of Family Physicians.¹³³ The reasons stated by the New Jersey legislature (quoted above) would appear equally applicable to contraceptive services.

One aspect of the related public health problem caused by pregnancies among unwed teenage girls is evidenced by illegitimacy statistics in the United States for the years from 1965 to 1968. Illegitimacy rates in older age groups declined during these years coincident with the increase in family planning services available to postpartum women. However, illegitimacy rates of girls 15–19 rose by 18 percent in this period.¹³⁴

Treatment of Minors Related to Pregnancy

At least 16 states now provide specifically that minors may consent to medical and surgical treatment related to pregnancy.¹³⁵ While this has been held by a court in at least one state to include therapeutic abortion,¹³⁶ it is not clear to what extent "treatment related to pregnancy" will be construed to include

contraception, i.e., the prevention of pregnancy. The one judicial statement found on this question was that the prevention of pregnancy is not included.¹³⁷

One Attorney General, interpreting a statute which has since been amended, stated that whether or not family planning services may be given to an unmarried minor younger than 18 without parental consent where statutory language is in terms of treatment related to pregnancy "would depend in each instance on a determination of whether the medical treatment was given in connection with pregnancy or childbirth"; he cited "the myriad types and possibilities of medical treatment which may be offered as an adjunct to family planning services."¹³⁸

The Question of Liability for Contraceptive Services to Minors

We have seen that under the old common law rule, a doctor who treated a minor without parental consent in circumstances not adding up to one of the common law exceptions could be held liable in a civil suit for assault and battery or malpractice.¹³⁹ However, we have found no case holding a doctor liable for providing contraceptive services to a minor without parental consent and no case holding a physician liable for supplying *any* medical service to a minor without parental consent where the minor was older than 15 and the treatment was for the minor's benefit and performed with the minor's consent.¹⁴⁰

Moreover, any assault thus committed was a so-called "technical assault" as distinguished from the usual assault with intent to harm. We know of no case where a physician treating a minor without parental consent has been charged with the *crime* of assault and battery. Bona fide medical treatment, even if unauthorized, cannot constitute criminal assault and battery because no unlawful intent can be shown.¹⁴¹

Many states have statutes which make it a crime to contribute to the delinquency of a minor or impair the morals of a minor or, as in New York, "endanger the welfare of a minor."¹⁴² However, these statutes have not been applied to a physician or a health facility for providing contraceptive treatment to minors and we know of no case where a doctor has ever been convicted, or a layman's conviction has ever been finally upheld, for distribution of contraceptive information or services to minors. We know of only three instances of attempted prosecution under such laws for distribution of contraceptive information or services. In an Ohio case,¹⁴³ a mother was charged with contributing to her daughter's delinquency by advising her to use contraceptives (if, contrary to the mother's insistence, the daughter did get sexually involved). The highest court in Ohio held that the mother could not be convicted because she was exercising her right of

free speech. The mother had not furnished her daughter with contraceptive devices. In the same year this case was decided, Ohio deleted the entire restriction relating to the sale and advertising of articles "for the prevention of conception" from its Criminal Code.¹⁴⁴

In Virginia, a physician was arrested in October, 1971, for allegedly contributing to the delinquency of a 17-year-old girl by prescribing birth control pills without her parent's consent.¹⁴⁵ The charges were promptly dismissed. As we have seen, Virginia is one of the nine states which specifically allow minors to consent to birth control services. In the summer of 1971, William Baird was arrested in New York while lecturing on birth control on the charge that he was "endangering the welfare of" a 14-month-old infant whose mother had brought her to a lecture.¹⁴⁶ Those charges were also quickly dropped. Baird was also prosecuted under a Massachusetts law (which prohibited the distribution of contraceptives except to married persons) for giving an unmarried woman contraceptive foam at the close of his lecture on contraception to a group of students at Boston University. Baird's conviction on this charge was recently reversed by the U.S. Supreme Court on the ground that the Massachusetts statute discriminated unconstitutionally between the married and the unmarried.¹⁴⁷ Baird was not prosecuted by Massachusetts for contributing to the delinquency of a minor, although many of the college students present must have been minors.

Increasingly, there has been widespread federal and state recognition of the rights of minors to birth control information and services. Under the 1967 amendments to Title IV of the Social Security Act (Aid to Families with Dependent Children) and the federal regulations issued pursuant thereto, state and local welfare agencies are required to provide medical contraceptive services to eligible persons "without regard to marital status, age or parent-hood." (See Federal Laws and Policy, above: Title IV A-Social Security Act, as Amended: Service Programs for Families and Children). However, the DHEW Social and Rehabilitation Service *Title IV A Services Guidelines*, issued in 1969, added the following statement: "In respect to youths, voluntary consent includes parental consent if such is required by State law."¹⁴⁸

In practice, many state health and welfare departments provide family planning services to minors on their own consent. (See Summary and Analysis, State Health and Welfare Department Policies Relating to Family Planning and Voluntary Sterilization, below.) In the context of these policies, and of the lack of criminal intent referred to above, and of the many state laws which are expanding minors' rights to medical treatment, there seems little likelihood of prosecution of physicians or other author-

ized persons who provide minors with contraceptive information or services. For this reason, we have not discussed these juvenile delinquency or other criminal statutes in the individual state profiles.

Only one state has a specific restriction relating to the age of the purchaser to whom a pharmacist may sell contraceptives (New York),¹⁴⁹ and two states have age restrictions for the sale of prophylactics (Nebraska¹⁵⁰ and Utah¹⁵¹). The New York statute makes it a misdemeanor for any person other than a pharmacist to sell or distribute contraceptives and prohibits their sale and distribution to persons under 16. These restrictions, however, do not apply to physicians. Similarly, the Nebraska and Utah statutes prohibit the sale of prophylactics by licensed pharmacists to anyone who is not married or older than 18, except that sales may be made by physicians or upon their order.

A Note on Confidentiality

Although it is not within the scope of this study to discuss all aspects of the doctor-patient relationship, certain questions of confidentiality related to minors will be considered. A physician who provides a minor with contraceptive services must decide whether to advise the minor's parents of the services he has rendered. In many cases, the minor may be expected to object to any such disclosure.

It is a guiding principle of medical ethics that "a physician may not reveal the confidences entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."¹⁵²

Moreover, many states have laws providing that a physician may not disclose information derived from professional contacts with the patient without first obtaining the patient's consent.¹⁵³ In a number of cases, physicians have been held liable for damages for disclosing confidential communications acquired in a professional capacity.¹⁵⁴

However, the law recognizes certain situations where the doctor may—and, indeed, sometimes is obligated to—reveal the patient's confidences. The clearest case is where the patient is found to be suffering from a serious contagious disease (mainly VD). Here the physician is generally required by state law to report that disease to the board of health, and he is permitted to disclose the disease to persons who might otherwise become infected.¹⁵⁵ Disclosure has been permitted in other situations as well.¹⁵⁶ The New Jersey Supreme Court has stated that "disclosure may, under . . . compelling circumstances, be made to a person with a legitimate interest in the patient's health,"¹⁵⁷ while a New York court has pointed out that the physician must weigh a "delicate balance of conflicting duties."¹⁵⁸

It has been held in two cases that a physician may

reveal to the husband information obtained in the course of treating the wife.¹⁵⁹ It does not necessarily follow that the doctor can reveal to parents information obtained in the course of treating their child. There is virtually no case law on the question of what a physician may disclose to the parents of his minor patients; the few cases found on this subject are inconclusive.¹⁶⁰ In deciding this question, a court might consider the age and maturity of the child, the nature of the service rendered and the degree of risk involved to the life and/or health of the patient.

Many states have attempted to deal with this situation by enacting statutory provisions which are designed usually to protect the physician whether or not he decides to notify the parents. Confidentiality provisions are found in the different types of laws permitting minors to consent to medical care. The most common provision is found in statutes allowing minors to consent to examination and treatment for venereal disease. Confidentiality provisions are also, however, found in statutes permitting minors to consent to medical treatment for pregnancy, and in the small but significant number of statutes which apply to all medical care of minors, including contraceptive services.

At least 28 states¹⁶¹ have statutory provisions regarding the confidentiality of medical treatment of minors. Before discussing these provisions in detail, we will briefly summarize them. All but four of the 28 states provide that the physician who treats a minor need not notify the parents;¹⁶² and of those 24, all but eight specify that he may advise them of treatment given or needed.¹⁶³ Four states¹⁶⁴ require the physician to notify the parent where the minor is found to have venereal disease or to be pregnant or require hospitalization. A fifth state requires notification in cases of surgery only.¹⁶⁵ Two states¹⁶⁶ provide that the physician shall not notify the parents of any examination or test where the minor is found not to be pregnant or afflicted with venereal disease.

The six states with comprehensive statutes covering medical treatment of minors which have enacted special provisions regarding confidentiality¹⁶⁷ permit the physician to notify the parents but do not require him to do so. While these six statutes apply to physicians who provide minors with contraceptive services, and the statutes of three other states¹⁶⁸ cover contraceptive services rendered to a minor who is or professes to be married or pregnant or afflicted with VD, the great majority of states do not have statutes applicable to the confidentiality of contraceptive services to minors (since most of the statutes discussed below relate only to treatment for VD). In many states, therefore, the law provides no clear guide for the physician as to the extent to which he may or must respect the confidence of the minor for whom he provides contraceptive services.

We shall now consider in detail the statutory pro-

visions regarding confidentiality which have been enacted in 28 states.

Six states have passed statutes regarding confidentiality which clearly apply to physicians rendering contraceptive services to minors: California, Minnesota, Mississippi, Kentucky, Maryland and Oregon. The latter three apply to contraceptive services to minors specifically. The Kentucky statute provides that a physician may prescribe for and treat any minor for contraception without the consent of or notification to the parents or guardian but may inform the parent or guardian of any treatment given or needed where, in his judgment, informing the parent or guardian would benefit the health of the minor patient.¹⁶⁹ Maryland and Oregon both authorize minors to consent to contraceptive services, and provide that the physician may advise the parents or guardian as to the treatment given or needed without the consent of the patient.¹⁷⁰

California and Minnesota have laws authorizing a minor who is living separate and apart from his parents or guardian and who is managing his own financial affairs, regardless of the source of his income, to consent to medical care in general; in California, the minor must also be 15 years of age or older. The California statute provides that a physician may, with or without the consent of the minor patient, advise the parents or guardian of the treatment given or needed if the physician has reason to know, on the basis of information given him by the minor, the whereabouts of the parent or guardian.¹⁷¹ The Minnesota statute provides that the physician may inform the parent or guardian of any treatment given or needed where, in his judgment, failure to inform the parent would seriously jeopardize the health of the minor patient.¹⁷² This Minnesota confidentiality provision, unlike the one in California, applies also where the minor is enabled to consent because he or she is married or has borne a child or is consenting to health services for "pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse" and where emergency treatment is given.

We have seen that Mississippi has codified the "mature minor doctrine" enabling minors to consent to medical treatment if they have "sufficient intelligence to understand and appreciate the consequences of the proposed treatment." A Mississippi statute also authorizes physicians to treat minors for venereal disease without obtaining the consent of or informing the parent or guardian. In addition, Mississippi has what appears to be a unique statute authorizing any person who has the power to consent to medical treatment for himself or another to waive the medical privilege for himself or the other person and to consent to the disclosure of medical information and the making and de-

livery of copies of medical or hospital records.¹⁷³ In some instances this might give a parent access to his child's medical and hospital records.

At least 18 states have statutes regarding the right of a physician to advise the parents of a minor who is suffering from venereal disease (or, in several instances, from drug addiction). Seven of these states provide that the physician may but shall not be obligated to inform the parent as to the treatment given or needed;¹⁷⁴ of the seven, six stipulate that such information may be given without the consent, or over the express objection, of the minor.¹⁷⁵

Another eight states simply provide that a physician may treat a minor for venereal disease without the consent of or notification to the parents.¹⁷⁶ Iowa provides that "the physician shall notify the parents of such minor child that the child does have a venereal disease when the results of the diagnosis indicate that the child might communicate the disease to other members of his family."¹⁷⁷ Nebraska requires the treating physician to send a letter to the parent or guardian of any child younger than 16, and any unemancipated minor older than 16, requesting the parent or guardian to come in to discuss the child's health problem.¹⁷⁸ Vermont requires that the parents or guardian be notified if the child's condition requires immediate hospitalization.¹⁷⁹

Hawaii and Missouri have statutes enabling minors to consent to medical treatment for pregnancy and venereal disease. The Hawaii statute requires the physician to inform the parent or guardian of any patient younger than 18 who is diagnosed as pregnant or afflicted with venereal disease; if the young patient is not diagnosed as pregnant or afflicted with venereal disease, withholding of such information shall be within the physician's discretion.¹⁸⁰ The Missouri statute provides that the physician may, with or without the consent of the minor patient, advise the parents or guardian if he has reason to know their whereabouts. However, if the minor is found not to be pregnant or afflicted with a venereal disease, then no information with respect to any appointment, examination, test or other medical procedure shall be given to the parent, guardian, or any other person.¹⁸¹

A Delaware statute, which gives any minor who professes to be either pregnant or afflicted with a venereal disease the right to consent to any medical treatment, provides that the physician may, in his discretion, either provide or withhold from the parents or guardian of the minor such information as he "deems to be advisable under the circumstances, having primary regard for the interests of the minor." However, notice of intention to perform any operation must be given to the parents or guardian at their last-known address, if available, by telegram; but the operation may proceed forthwith if there is

reason to believe that delay would endanger the life of or cause irreparable injury to the minor.¹⁸²

Montana and New Jersey have statutes authorizing a minor who is (or, in Montana, professes to be) married, pregnant or afflicted with a venereal disease to consent to any medical or surgical care. New Jersey provides that the physician "may, but shall not be obligated to, inform" the parent or guardian of the minor as to the treatment given or needed, and may do so "even over the express refusal of the minor patient."¹⁸³ Montana has a similar provision, but stipulates, like Missouri, that if the minor is found not to be pregnant or not afflicted with venereal disease, then no information with respect to any appointment, examination or other medical procedure shall be given to the parent or guardian.¹⁸⁴

Constitutional Rights of Minors

Some recent cases have developed new doctrines articulating the constitutional rights of minors. From these can be inferred the principle that a teenage girl should have the same right as her adult sister to decide whether or not she shall bear a child. The U.S. Supreme Court decision in *Griswold v. Connecticut*¹⁸⁵ (discussed above in the "Summary and Analysis of State Laws Relating to Contraception") has been interpreted by the California Supreme Court as recognizing a "right of privacy in matters related to marriage, sex and the family" as well as "the fundamental right of the woman to choose whether to bear children."¹⁸⁶ A number of lower federal courts, in holding state antiabortion statutes unconstitutional, have recognized a woman's right to determine whether or not she wishes to bear a child, at least in the early stages of pregnancy;¹⁸⁷ appeals to the U.S. Supreme Court have been argued in two of these cases but on June 26, 1972, the U.S. Supreme Court scheduled them for reargument in the 1972-1973 term of court. In *Eisenstadt v. Baird*¹⁸⁸ (discussed above and in the Summary and Analysis of State Laws Relating to Contraception), the U.S. Supreme Court struck down a state statute which, *inter alia*, prohibited distribution of contraceptives except to married persons, holding that such a limitation violated the rights of single persons under the Equal Protection Clause of the Fourteenth Amendment.

All of these pregnancy-related cases dealt with the constitutional rights of adults. There are a number of decisions by the U.S. Supreme Court and lower courts, however, in other contexts, that "children are 'persons' within the meaning of the Bill of Rights."¹⁸⁹ Thus, the U.S. Supreme Court has held that minors have the right to basic procedural safeguards in juvenile delinquency proceedings¹⁹⁰ and that public school students have the right to wear black arm bands as a peaceful protest against the Vietnam war.¹⁹¹ In the arm band case, the U.S. Su-

preme Court said: "Students in school as well as out of school are 'persons' under our Constitution. They are possessed of fundamental rights which the State must respect, just as they themselves must respect their obligations to the State."¹⁹²

The U.S. Supreme Court has not yet ruled on whether public school students have the right to wear their hair at any length desired; it has denied *certiorari* (a form of appeal which may be granted at the Court's discretion) in two cases where the lower courts sustained the school board's right to regulate students' hair length¹⁹³ and in one case where the lower court overruled the school board.¹⁹⁴

Justice William O. Douglas dissented from the U.S. Supreme Court's most recent refusal of *certiorari* in a case where the lower court had sustained the school board, pointing out that the lower federal courts are deeply divided on this issue, with students having won in about half the cases.¹⁹⁵ In his dissenting opinion, Justice Douglas expressed the view that a denial of public education to a student because of his hair style raises a serious question of equal protection of the law.

In one of the cases cited by Justice Douglas, a federal court overruled a school board which suspended a 17-year-old high school student for wearing his hair long. In its opinion, the U.S. Court of Appeals for the First Circuit quoted an early Supreme Court decision as follows:

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, 'The right to one's person may be said to be a right of complete immunity: to be let alone'.¹⁹⁶

The possession and control of one's own person would seem to include a choice as to whether one wishes to bear a child or indeed obtain any needed medical service. In a recent case decided by a Utah lower court, it was held that the defendant, Planned Parenthood Association of Utah, had an affirmative duty under its contract to provide family planning assistance and services to the plaintiff and "all others similarly situated not under the age of fourteen."¹⁹⁷ The court held "that to deny the plaintiff and others similarly situated would be violating the Constitution of the United States."

Another constitutional argument for the teenager's right to contraceptive services can be made in a state such as California which, by statute, provides that birth control services shall be provided to all "former, current or potential" public assistance recipients (between the ages of 15 and 44) without regard to age or marital status and without parental consent.¹⁹⁸ Yet a bill, passed by both houses of the California legislature, which would have allowed all minors to receive contraceptive services without

parental consent, was recently vetoed by the Governor. It seems discriminatory, and may be a denial of equal protection, for a state to eliminate the requirement of parental consent for minors from only one segment of the population, i.e., minor public assistance recipients as defined, selected on an economic basis.

Although there have as yet been no judicial determinations, other than the Utah decision discussed above, in this area, minors may have a constitutional right to request and consent to medical contraceptive services based either on a right of privacy, a right to equal protection of the laws or as part of the basic liberty guaranteed by the due process clause of the Fourteenth Amendment to the Constitution.

Conclusion

There is a strong nationwide trend toward recognition of the rights of minors to medical care. A number of state legislatures have adopted general minors' "medical consent laws" which remove ambiguous legal barriers to rendering needed medical services to minors without parental consent, barriers which often prevent minors from obtaining needed medical services.

Many states have enacted laws providing that minors may obtain medical care without parental consent in special situations where teenagers are exposed to high medical risks. Almost all the states now have such laws covering actual and suspected venereal disease, and many cover pregnancy and birth control. The trend appears to be toward general acceptance of the right of all minors to medical care without parental consent in these high risk areas. In addition, many states have lowered the age of majority either for all purposes or specifically for consent to medical care; the nation appears to be moving toward general acceptance of 18 as the age of majority, with many states setting a lower age for consent to all or some medical care.

Even where no new legislation has been enacted, the courts have expanded exceptions to the old common law rule and permit medical treatment of minors without parental consent in emergencies, where the minor is emancipated or "neglected," and, under the "mature minor rule," i.e., where the minor is old enough and intelligent enough to understand the nature and consequences of the treatment and it is for his benefit.

Although the laws of the various states and territories differ considerably, there has been a marked expansion both of the categories of minors whom a licensed physician may treat without parental consent and of the kinds of situations, notably sex-related health care, where a minor can consent to his or her own medical services.

Footnotes to "State Laws Relating to Contraceptive Services to Minors"

1. 70 C.J.S. Physicians & Surgeons § 48, p. 968 (1951); Shar-tel & Plant, *The Law of Medical Practice* 25-26 (1959); *Zoski v. Gaines*, 271 Mich. 1, 260 N.W. 99 (1935); *Rogers v. Sells*, 178 Okla. 103, 61 P. 2d 1018 (1936); *Moss v. Rishworth*, 222 S.W. 225 (Tex. Comm'n of App. 1920).
2. "While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to mal-practice, even though negligence is not charged." *Physicians' and Dentists' Business Bureau v. Dray*, 8 Wash. 2d 38, 111 P. 2d 568, 569 (1941), quoted in *Maercklein v. Smith*, 129 Col. 72, 266 P. 2d 1095 at 1098 (1954). See also *Brown v. Wood*, 202 So. 2d 125 (D. Ct. of App. 2d D. Fla. 1967).
3. Dissenting opinion of Justice William O. Douglas, *Wisconsin v. Yoder*, U.S. Supreme Court No. 70-110, May 15, 1972, Footnote 3, and works cited therein.
4. Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Georgia, Idaho, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Mississippi, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio (if mature and intelligent), Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin.
5. Alabama, California, Colorado, Georgia, Illinois, Kansas, Kentucky, Maryland, Mississippi, Oregon, Tennessee, Virginia. See individual state profiles for age at which minor can consent to contraceptive services.
6. *Jackovach v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931); *Wells v. McGehee*, 39 So. 2d 196 (La. 1949); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912); *Sullivan v. Montgomery*, 155 Misc. 448, 279 N.Y. Supp. 575 (1935); *Browning v. Hoffman*, 90 W. Va. 568, 111 S.E. 492 (1922).
7. See, e.g., *Rogers v. Sells*, *supra* note 1; *Moss v. Rishworth*, *supra* note 1. See, however, *United States v. Vuitch*, 402 U.S. 62 (1971), where the U.S. Supreme Court held that in a criminal abortion proceeding the prosecution must bear the burden of proving that the doctor's conduct did not fall within an exception to the rule. The opinion contains language which by implication suggests that it would be the person attacking the physician's finding of an emergency who would have the burden of proof.
8. Act. No. 2281 (1971).
9. Ga. Code Ann. § 88-2905 (1971).
10. Ill. Ann. Stat. Ch. 91, § 18.3 (Smith-Hurd 1972 Cum. Supp.).
11. Ky. Rev. Stat. § 214.185 (as amended by S.B. 309 (1972)).
12. Md. Ann. Code, art. 43, § 135 (a) (4) (1971).
13. Mass. Ann. Laws Ch. 112, § 12E (Cum. Supp. 1970).
14. S.F. No. 1496, Ch. 544, § 144.344 (1971).
15. Miss. Code Ann. § 7129-83 (Cum. Supp. 1971).
16. N.Y. Pub. Health Law § 2504 (added June 2, 1972).
17. N.C. Gen. Stat. § 90-21.1 (Cum. Supp. 1969).
18. Pa. Stat. tit. 35, § 10104 (1971 Cum. Supp.).
19. R.I. Gen. Laws Ann. § 23-51-1 (Supp. 1971) (any person 16 or over or married).
20. Ariz. Rev. Stat. § 44-133 (1967); N.M. Stat. Ann. § 12-12-4 (1967); Nev. Rev. Stat. § 129.040 (1969).
21. See R. L. Day, "Factors Influencing Offspring," *American Journal of Diseases of Children*, 113:179, 1967; Daniels, *Medical, Legal and Social Indications of Contraceptives for Teenagers*, Child Welfare Vol. L. No. 3, p. 150 et seq. (March 1971); H. Wallace, *Teenage Pregnancy*, *Am. J. Obst. & Gynec.*, Aug. 15, 1965; J. Grant, *Biologic Outcomes of Adolescent Pregnancy; An Administrative Perspective*, *Perspectives in Maternal and Child Health*, School of Hygiene and Public Health, Johns Hopkins Univ., July, 1970. See also: N. R. Butler, and D. G. Bonham, *Perinatal Mortality*, Edinburgh and London, 1963, E. & S. Livingstone, Ltd.; J. A. Heady, and J. N. Morris, *J. Obs. & Gynaec. Brit. Emp.* 66:577, 1959; J. Yerushalmy, J. M. Bierman, D. H. Kemp, A. Connor and F. E. French, *Am. J. Obst. & Gynec.* 71:80, 1956, R. Illsley, "The Social Correlates of Childbirth," paper for Perinatal Research Committee, Association for the Aid of Crippled Children, 1964; and U.S. Dept. of Health, Education and Welfare: *International Comparison of Perinatal and Infant Mortality: The United States and Six Western European Countries*, National Center of Health Statistics, 1967, Series 3, No. 6, Government Printing Office; A. Kessler, "Maternal and Infant Mortality," *Proceedings of the International Planned Parenthood Federation*, Santiago, Chile, 1967; J. Yerushalmy, C. E. Palmer, and M. Kramer: *Pub. Health Reports*, 55:1195, 1940; F. S. Jaffe and S. Polgar, "Epidemiological Indications for Fertility Control," *Journal of the Christian Medical Association of India*, September, 1967, p. 12; J. Pakter, J. H. Rosner, H. Jacobziner, and F. Greenstein, *Am. J. Pub. Health*, 51:846, 1961.
22. As to child abuse, according to one national study, 9.29 percent of abusing mothers in 1967 were younger than 20 years of age (David Gil, *Violence Against Children*, Harvard Univ. Press, Cambridge, Mass., 1970, p. 109); while only 2.4 percent of mothers 14-44 were younger than 20 (U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 211, "Previous and Prospective Fertility: 1967," U.S. Government Printing Office, Washington, D.C., 1971, p. 29). See also: B. Simons, M.D., et al., "Child Abuse-Epidemiologic Study of Reported Cases," *N.Y. State Journal of Medicine*, Nov. 1, 1966, pp. 2783-2787.
23. Ala. Act No. 2281 (1971) (any minor who is 14 or older, or has graduated from high school, or is married, divorced or pregnant or has borne a child); Ariz. Rev. Stat. Ann. § 44-132 (1967) (emancipated and married minors); Cal. Civ. Code § 25.6 (West Supp. 1971) (married minors); 25.7 (minors on active duty in the armed services), and § 34.6 (a minor who is 15 or over and living separate and apart from his parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing his own financial affairs, regardless of the source of his income); Colo. Rev. Stat. Ann. § 41-2-13 (added by 1971 Session Laws, Ch. 124, S.B. No. 169) (married minors and any minor 15 or older who is living separate and apart from his parents or legal guardian and is managing his own financial affairs, regardless of the source of his income); Del. Code Ann. tit. 13, § 707 (Supp. 1970) (married minors); Ga. Code Ann. Ch. 88-29 (1971) (married minors); Ill. Ann. Stat. Ch. 91, § 18.1 (Smith-Hurd 1972 Cum. Supp.) (married minors and pregnant minors); Ind. Ann. Stat. § 35-4409 (1969) (emancipated minors and married minors living with their spouses); Ky. S.B. 309 (1972) (emancipated minor or any minor who has contracted a lawful marriage or borne a child); Md. Ann. Code, art. 43, § 135 (1971) (minor who is married or the parent of a child); Minn. S.F. No. 1496, Ch. 544, § 144.341 (1971) (any minor who is living separate and apart from his parents or legal guardian whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence and who is managing his own financial affairs, regardless of the source or extent of his income) and § 144.342 (any minor who has been married or has borne a child); Miss. Code Ann. § 7129-81 (1971 Cum. Supp.) (emancipated and married minors); Mo. Rev. Stat. § 431.065 (1970 Cum. Supp.) (married minors and minor parents); Mont. Rev. Codes

- Ann. § 69-6101 (1970) (minor who is or professes to be married or pregnant); Nev. Rev. Stat. § 129.030 (1969) (emancipated and married minors); N.J. Stat. Ann. § 9:17 A-1 (1971 Supp.) (married minors and pregnant minors); N.M. Stat. Ann. § 12-12-1 (1967) (emancipated and married minors); N.Y. Pub. Health Law § 2504 added June 2, 1972) (minor who is 18 or older or has married or is the parent of a child); N.C. Gen. Stat. § 90-21.5 (a) (1971) (minor who is 18 or older or emancipated); Pa. Stat. tit. 35, § 10101 (1971 Cum. Supp.) (any minor who is 18 or older or has graduated from high school or has married or has been pregnant); S.C. Code § 11-157 (1970 Cum. Supp.) (married minors).
24. *Smith v. Seibly*, 72 Wash. 2d 16, 431 P. 2d 719 (1967); *Bach v. Long Island Jewish Hospital*, 49 Misc. 2d 207, 267 N.Y.S. 2d 289 (Sup. Ct. Nassau Co. 1966).
 25. See *Altieri v. Altieri*, 21 Conn. Super. 376, 155 A. 2d 758 (1959); *Tyler v. Gallop*, 68 Mich. 185, 35 N.W. 902 (1888); *Niesen v. Niesen*, 38 Wis. 2d 599, 157 N.W. 2d 660 (1968).
 26. *Gillikin v. Burbage*, 263 N.C. 317, 139 S.E. 2d 753, 757 (1965); see 59 American Jurisprudence 2d, Parent and Child § 93 et seq. (1971).
 27. *Niesen v. Niesen*, *supra* note 25, 157 N.W. 2d at 662.
 28. See, e.g., Alaska Stat. § 25.20.020 (1962) (females only); Fla. Stat. Ann. § 743.01 (as amended 1971 Laws Ch. 71-147); Iowa Code Ann. § 599.1 (1950); Neb. Rev. Stat. § 38-101 (1969); Ore. Rev. Stat. § 109.520 (1969); Tex. Family Code § 4.03 (1971); Utah Code Ann. § 15-2-1 (1962); Wash. Rev. Code § 26.28.020 (1961) (females married to a person of full age). In California and Kansas any person 18 or older and married may enter into any contract. Cal. Civ. Code § 25 (West Supp. 1971); Kan. Stat. Ann. § 38-101 (1970 Supp.). In Idaho any male 18 or over and any female under 18 who has been married may enter into a contract. Idaho Code Ann. § 32-101 (1963). In Alabama and Louisiana a married minor of 18 or older is relieved of all the disabilities of minority. Ala. Code tit. 34, § 76 (1959); tit. 34, § 76 (1) (Cum. Supp. 1969); La. Civ. Code Art. 382 (1971 Cum. Supp.).
 29. *Crook v. Crook*, 80 Ariz. 275, 296 P. 2d 951 (1956); *Matter of Estate of Hardaway*, 26 Ill. App. 2d 493, 168 N.E. 2d 796 (1960); *Inhabitants of Taunton v. Inhabitants of Plymouth*, 15 Mass. 203 (1818), *Rinaldi v. Rinaldi*, 94 N.J. Eq. 14, 118 Atl. 685 (1922); *Cochran v. Cochran*, 196 N.Y. 86, 89 N.E. 470 (1909); *Bach v. Long Island Jewish Hospital*, *supra* note 24; *In re Palumbo*, 172 Misc. 55, 14 N.Y.S. 2d 329 (Dom. Rel. Ct. 1939); *Church v. Hancock*, 261 N.C. 764, 136 S.E. 3d 81 (1964); *Smith v. Seibly*, *supra* note 24; *La Crosse County v. Vernon County*, 233 Wis. 664, 290 N.W. 279 (1940).
 30. *Parton v. Hervey*, 67 Mass. (1 Gray) 119 (1854); *Fodor v. Kunie*, 92 N.J. Eq. 301, 112 Atl. 598 (1921); *Eliot v. Eliot*, 77 Wis. 634, 46 N.W. 806 (1890).
 31. For a table showing the age requirements of every American jurisdiction as of July 1, 1965, see Am. Jur. 2d Desk Book, Document 124 (Cum. Supp. 1971).
 32. An earlier view was that an infant who married under the age of consent could deny and avoid the marriage without any judicial decree. Keezer, Marriage and Divorce 204-206 (3d ed. 1946).
 33. See *Duley v. Duley*, 151 A. 2d 255 (D. of Columbia Mun. App. 1959); *People ex rel. Mitts v. Ham*, 206 Ill. App. 543 (1917); *Mangrum v. Mangrum*, 310 Ky. 226, 220 S.W. 2d 406 (1949); *State in Interest of I.*, 68 N.J. Super. 598, 173 A. 2d 457 (1961); *State v. Ward*, 204 S.C. 210, 28 S.E. 2d 785 (1944); *Eliot v. Eliot*, 77 Wis. 634, 46 N.W. 806 (1890) (decided under prior statute); 52 Am. Jur. 2d, Marriage § 14 (1970).
 34. *Irby v. State*, 57 Ga. App. 717, 196 S.E. 101 (1938); *Noble v. Noble*, 299 Mich. 565, 300 N.W. 885 (1941) (applying Indiana law); *Melcher v. Melcher*, 102 Neb. 790, 169 N.W. 720 (1918); *Fitzpatrick v. Fitzpatrick*, 6 Nev. 63 (1870); *Aldrich v. Bennett*, 63 N.H. 415 (1885) (under prior statute); *Berry v. Winistorfer*, 55 N.D. 310, 213 N.W. 26 (1927); *Needam v. Needam*, 183 Va. 681, 33 S.E. 2d 288 (1945). See also *Fodor v. Kunie*, *supra* note 30; *Cushman v. Cushman*, 80 Wash. 615, 142 Pac. 26 (1914); 52 Am. Jur. 2d, Marriage § 15 (1970).
 35. E.g., *Irby v. State*, *supra* note 34; *Cochran v. Cochran*, 196 N.Y. 86, 89 N.E. 470 (1909); *Holman v. Holman*, 35 Tenn. App. 273, 244 S.W. 2d 618 (1951). See Annotation — Minor — Implied Emancipation, 165 A.L.R. 723, 745 (1946); Keezer, Marriage and Divorce 208-210 (3d ed. 1946). But see *Austin v. Austin*, 167 Mich. 164, 132 N.W. 495 (1911).
 36. *State ex rel. Scott v. Lowell*, 78 Minn. 166, 80 N.W. 877 (1899); *Klinebell v. Hilton*, 2 Ohio L. Abs. 637 (Ohio App. 1924); *People ex rel. Mitts v. Ham*, *supra* note 33. To same effect, for a minor son, see *Commonwealth v. Graham*, 157 Mass. 73, 31 N.E. 706 (1892). But see *Wolf v. Wolf*, 194 App. Div. 33, 185 N.Y. Supp. 37 (2d Dep't 1920) (marriage of son under statutory age of consent without father's approval did not emancipate him); *White v. Henry*, 24 Me. 531 (1845) (same).
 37. *United States v. Williams*, 302 U.S. 46, rehearing denied, 302 U.S. 779 (1937); *Iroquois Iron Co. v. Industrial Commission of Illinois*, 294 Ill. 106, 128 N.E. 289 (1920); *Wallace v. Woods*, 271 N.E. 2d 487 (Ind. App. 1971); *Swenson v. Swenson*, 241 Mo. App. 21, 227 S.W. 2d 103 (1950); *Baker v. Baker*, 41 Vt. 55 (1868).
- "The power of the United States may be exerted to supersede parents' control and their right to have the services of minor sons . . . [E]nlistment of a minor for military service is not voidable by him or his parents . . . It operates to emancipate minors at least to the extent that by enlistment they become bound to serve subject to rules governing enlisted men and entitled to have and freely to dispose of their pay." *United States v. Williams*, *supra*, 302 U.S. at 48-49.
- A California statute permits minors on active duty in the armed services to consent to medical and surgical care. Cal. Civ. Code § 25.7 (West Supp. 1971). A Michigan statute which defines emancipation for all purposes provides that emancipation occurs during the period when the minor is on active duty with the armed forces of the United States. Mich. Comp. Laws Ann. § 722.4 (Cum. Supp. 1972).
38. *In re Fiihr*, 184 N.W. 2d 22 (Sup. Ct. Minn. 1971); *Brosius v. Barker*, 154 Mo. App. 657, 136 S.W. 18 (1911); *Cohen v. Delaware*, L.&W.R.R., 150 Misc. 450, 269 N.Y. Supp. 667 (Sup. Ct. N.Y. Co. 1934); *Harris Irby Cotton Co. v. Duncan*, 57 Okla. 761, 157 Pac. 746 (1915); *Kidd v. Joint School District No. 2*, 194 Wis. 353, 216 N.W. 499 (1927).
 39. *Matter of Stillman v. School District*, 60 Misc. 2d 819, 304 N.Y.S. 2d 20 (Sup. Ct. Nassau Co. 1969), *aff'd*, 34 App. Div. 2d 553 (2d Dep't 1970).
 40. *Martinez v. Southern Pacific Co.*, 288 P. 2d 868 (Cal. Sup. Ct. 1955); *Wood v. Wood*, 135 Conn. 280, 63 A. 2d 586 (1948); *Jackson v. Citizens Bank & Trust Co.*, 53 Fla. 265, 44 So. 516 (1907); *Owen v. Owen*, 234 So. 2d 165 (Fla. D. Ct. of App. 1st D. 1970), *cert. denied*, 237 So. 2d 763 (Fla. Sup. Ct. 1970); *Haugh, Ketcham & Co. Iron Works v. Duncan*, 2 Ind. App. 264, 28 N.E. 334 (1891); *Penn. R. Co. v. Patesel*, 118 Ind. App. 233, 76 N.E. 2d 595 (1948); *Carricato v. Carricato*, 384 S.W. 2d 85 (Ky. 1964); *Crosby v. Crosby*, 230 App. Div. 651, 246 N.Y. Supp. 384 (3rd Dep't 1930); *Giovagnoli v. Fort Orange Construction Co.*, 148 App. Div. 489, 133 N.Y. Supp. 92 (3rd Dep't 1911); *Gillikin v. Burbage*, 263 N.C. 317, 139

- S.E. 2d 753 (1965); *Townsen v. Townsen*, 101 Ohio App. 85, 137 N.E. 2d 789 (1954); *Parker v. Parker*, 230 S.C. 28, 94 S.E. 2d 12 (1956); *Foran v. Kallio*, 56 Wash. 2d 769, 355 P. 2d 544 (1960). But see *Lufkin v. Harvey*, 131 Minn. 238, 154 N.W. 1097 (1915); *Detwiler v. Detwiler*, 162 Pa. Super. 383, 57 A. 2d 426 (1948).
41. *Jackson v. Citizens Bank & Trust Co.*, *supra* note 40; *Van Sweden v. Van Sweden*, 250 Mich. 238, 230 N.W. 191 (1930); *Williams v. Williams*, 91 N.J.S. 273, 219 A. 2d 895 (1966), *cert. denied* 222 A. 2d 22 (1966). But see *American Products Co. v. Villwock*, 7 Wash. 2d 246, 109 P. 2d 570 (1941); *Fiedler v. Potter*, 180 Tenn. 176, 172 S.W. 2d 1007 (1943).
 42. *Aetna Life Ins. Co. v. Industrial Accident Commission*, 175 Cal. 91, 165 Pac. 15 (1917); *Burdick v. Nawrocki*, 21 Conn. Super. 272, 154 A. 2d 242 (1959); *Mulder v. Achterhof*, 258 Mich. 190, 242 N.W. 215 (1932); *Cafaro v. Cafaro*, 118 N.J.L. 123, 191 Atl. 472 (1937); *Estes v. Estes*, 15 N.J. Misc. 305, 191 Atl. 107 (Workmen's Compensation Board 1937).
 43. See, e.g., Ark. Stat. Ann. § 34-2001 (Cum. Supp. 1969); Fla. Stat. Ann. § 62.011 (1969); V.I. Code tit. 16, §§ 231-254 (1957). It has been argued that "this is not a true emancipation," since its result is to remove the general disabilities of infancy rather than to extinguish parental rights and duties. 59 Am. Jur. 2d, Parent and Child § 93 (1971).
 44. See *Robinson v. Hathaway*, 150 Ind. 679, 50 N.E. 883 (1898); *Inhabitants of Camden v. Inhabitants of Warren*, 160 Me. 158, 200 A. 2d 419 (1964); *In re Sonnenberg*, 256 Minn. 571, 99 N.W. 2d 444 (1959); *Murphy v. Murphy*, 206 Misc. 228, 133 N.Y.S. 2d 796 (Sup. Ct. 1954); *Thompson v. Chicago, M. & St. P. Ry. Co.*, 104 Fed. 845 (Cir. Ct., D. Nebraska 1900).
 45. In addition to the states which define emancipation for purposes of consent to medical care: Michigan has a statute which defines emancipation for all purposes. Oklahoma has a statute which provides that the authority of a parent ceases upon the marriage of the child, and another statute which provides that a parent may relinquish to the child the right of controlling him and receiving his earnings. Nebraska has a statutory definition of emancipation for purposes of notification of parents whose child has VD (notification being required unless the child is 16 or older and emancipated). For discussion of these statutes, see individual state profiles.
 46. *Perkins v. Robertson*, 295 P. 2d 972 (Cal. D. Ct. App. 1956); *Carricato v. Carricato*, 384 S.W. 2d 85 (Ky. 1964); *Cafaro v. Cafaro*, 118 N.J. Law 123, 191 Atl. 472 (1937); *Bates v. Bates*, 62 Misc. 2d 498, 310 N.Y.S. 2d 26 (Fam. Ct. 1970); *Gillikin v. Burbage*, 263 N.C. 317, 139 S.E. 2d 753 (1965); *Bagyi v. Miller*, 3 Ohio App. 2d 371, 210 N.E. 2d 887 (1965); *Detwiler v. Detwiler*, 162 Pa. Super. 383, 57 A. 2d 426 (1948).
 47. See e.g., Ala. Act No. 2281 § 7 (1971); Colo. Rev. Stat. Ann. § 41-2-13 (added by 1971 Session Laws, Ch. 124, S.B. No. 169); Ky. Rev. Stat. § 214.185 (as revised by S.B. 209, 1972); Minn. S.F. No. 1496, Ch. 544, § 144.345 (1971); Miss. Code Ann. § 7129-82 (Cum. Supp. 1971); Pa. Stat. tit. 35, § 10105 (Cum. Supp. 1971).
 48. *Bonner v. Surman*, 215 Ark. 301, 220 S.W. 2d 431 (1949); *Lottinville v. Dwyer*, 68 R.I. 263, 27 A. 2d 305 (1942); *Foran v. Kallio*, 56 Wash. 2d 769, 355 P. 2d 544 (1960).
 49. *Van Sweden v. Van Sweden*, 250 Mich. 238, 230 N.W. 191 (1930); *Williams v. Williams*, 91 N.J.S. 273, 219 A. 2d 895 (1966), *cert. denied*, 222 A. 2d 22 (1966).
 50. *Warren v. DeLong*, 57 Nev. 131, 59 P. 2d 1165 (1936).
 51. *Inhabitants of Camden v. Inhabitants of Warren*, *supra* note 44; *In re Sonnenberg*, *supra* note 44.
 52. *Bach v. Long Island Jewish Hospital*, *supra* note 24.
 53. *Younts v. St. Francis Hospital*, 205 Kan. 292, 469 P. 2d 330 (1970); *Bakker v. Welsh*, 144 Mich. 632, 108 N.W. 94 (1906); *Bishop v. Shurly*, 237 Mich. 76, 211 N.W. 75 (1926); *Gulf & Ship Island R.R. v. Sullivan*, 155 Miss. 1, 119 So. 501 (1928); *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E. 2d 25 (1956); see *Bonner v. Moran*, 126 F. 2d 121 (D.C. Cir. 1941); *Smith v. Seibly*, 72 Wash. 2d 16, 431 P. 2d 719 (1967).
 54. Miss. Code Ann. § 7129-81 (1971 Cum. Supp.).
 55. N.H. Rev. Stat. Ann. § 318-B:12-a (Supp. 1971).
 56. *Supra* note 53.
 57. *Lacey v. Laird*, *supra* note 53.
 58. *Bakker v. Welsh*, *supra* note 53.
 59. *Supra* note 53.
 60. See Baker, *Court Ordered Non-Emergency Medical Care for Infants*, 18 Cleveland-Marshall Law Rev. 296 (1969).
 60. See Baker, *Court Ordered Non-Emergency Medical Care* S.W. 2d 816 (1964); *Mannis v. State of Arkansas*, 240 Ark. 42, 398 S.W. 2d 206 (1966), *cert. denied* 384 U.S. 972; *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E. 2d 769, *cert. denied* 344 U.S. 824 (1952); *State v. Perricone*, 37 N.J. 463, 181 A. 2d 751, *cert. denied* 371 U.S. 890 (1962); *In re Vasko*, 238 App. Div. 128, 263 N.Y. Supp. 552 (2d Dep't 933); *In re Rotkowitz*, 175 Misc. 948, 25 N.Y.S. 2d 624 (Children's Ct. 1941); *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S. 2d 641 (Fam. Ct. 1970), *aff'd*, 37 App. Div. 2d 668, 323 N.Y.S. 2d 253 (3d Dep't 1971); *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E. 2d 128 (Ohio Com. Pl. 1962). But see *In re Tony Tuttendario*, 21 Pa. Dist. 561 (1911); *In re Hudson*, 13 Wash. 2d 673, 126 P. 2d 765 (1942).
 62. *In re Sampson*, *supra* note 61.
 63. Cal. Welf. & Inst'n's Code § 10053.2 (1971).
 64. Colo. Rev. Stat. Ann. § 91-1-38 (Added by 1971 Sessions Laws, Chapter 161, S.B. No. 230).
 65. Ga. Code Ann. § 88-2904 (as amended effective July 1, 1972).
 66. Ill. Ann. Stat. Ch. 91, § 18.7 (Smith-Hurd 1972 Supp.).
 67. Ky. Rev. Stat. § 214.185 (as revised by S.B. 309, 1972).
 68. Md. Ann. Code art. 43, § 135 (1971).
 69. Ch. 381 [1971] Oregon Laws.
 70. Tenn. Code Ann. § 53-4607 (Cum. Supp. 1971).
 71. Va. Code Ann. § 32-137 (as amended by House Bill 378, effective July 1, 1972).
 72. D. of C. Reg. No. 71-27 (1971).
 73. The Alaska statute provides for information only. See Alaska profile.
 74. Iowa, Michigan, Nevada, New York, Ohio, West Virginia and Wyoming.
 75. Ark. Stat. Ann. § 57-103 (1948).
 76. Idaho Code Ann. § 32-101 (1963).
 77. Nev. Rev. Stat. § 129.010 (1969).
 78. Okla. Stat. Ann. tit. 15, § 13 (1966).
 79. S.D. Code § 26-1-1 (1967).
 80. Utah Code Ann. § 15-2-1 (1962).
 81. This distinction will be invalidated if three-fourths of the state legislatures ratify the proposed Amendment to the Constitution establishing equal rights for both sexes. House Joint Resolution 208 (passed by Congress on March 22, 1972).
 82. Chapter 218, Laws 1972 (effective May 5, 1972).
 83. Public Act No. 127 (signed May 9, 1972).
 84. (except for sale of alcoholic beverages and care of handicapped children) Ky. Rev. Stat. § 2.015 (1968).
 85. Chapter 598, H.P. 1581-L.D. 2038 (1972 First Special Session).
 86. (as of January 1, 1972) Act No. 79, Public Acts of 1971.
 87. Senate No. 992 (Official Copy Reprint), Ch. 81, 1972 laws (effective January 1, 1973).
 88. N.M. Stat. Ann. § 13-13-1 (1971).
 89. N.C. Gen. Stat. §§ 48A-1, 48A-2 (1971).
 90. N.D. Cent. Code § 14-10-01 (1971).

91. Tenn. Pub. Code, Ch. 162 (1971).
92. Vt. Stat. Ann. tit. 1, § 173 (as amended by Act No. 90, Public Acts of 1971).
93. Chapter 61, Acts of the Legislature, Regular Session, 1972.
94. Wis. Laws 1971, ch. 213 (effective March 23, 1972).
95. Wyo. Stat. Ann. § 14-1.1 (Cum. Supp. 1971) (contingent on November, 1972 referendum).
96. (any person at 19 and any female at marriage) Alaska Stat. §§ 25.20.010, 25.20.020 (1962).
97. Mont. Rev. Codes § 64-101 (Cum. Supp. 1971).
98. Hawaii Rev. Laws § 577.1 (1968).
99. (minority ends at age 20, or earlier upon marriage) Neb. Rev. Stat. § 38-101 (1969).
100. Del. Code Ann. tit. 6, § 2705 (1969).
101. Public Act 77-1229 (approved August 24, 1971). This act reduces the age of majority for some purposes to 18, including the age at which minors can enter into valid contracts (but not marriage contracts).
102. Ch. 726 [1971] Oregon Laws 1624.
103. Wash. Rev. Code § 26.28.010 (1971 Cum. Supp.); also see Wash. Laws, 1971, 1st Ex. Sess. Ch. 292, § 2 (5).
104. Colo. Rev. Stat. Ann. § 41-2-13 (added by 1971 Session Laws, Chapter 124, S.B. No. 169).
105. Pub. Act 304 (effective Oct. 1, 1971).
106. Ga. Code Ann. § 88-2904 (1971).
107. Ill. Ann. Stat. Ch. 91, § 18.1 (Smith-Hurd 1972 Cum. Supp.).
108. Md. Ann. Code art. 43, § 135 (1971).
109. See note 87 *supra*.
110. N.Y. Pub. Health Law § 2504 (signed by Governor Rockefeller June 2, 1972).
111. N.C. Gen. Stat. § 90-21.5 (1971).
112. Pa. Stat. tit. 35, § 10101 (1969).
113. House Bill 378, effective July 1, 1972.
114. Ch. 381 [1971] Oregon Laws 551.
115. The minor must live separate and apart from his parents and manage his own financial affairs, regardless of the source of his income. Cal. Civ. Code § 34.6 (West Supp. 1971).
116. Colo. Rev. Stat. Ann. § 41-2-13 (added by 1971 Session Laws, Chapter 124, S.B. No. 169).
117. Act No. 2281 (1971).
118. Kan. Stat. Ann. § 38-123b (1970 Supp.).
119. Act No. 2281 (1971).
120. Cal. Civ. Code §§ 25.6, 25.7, 34.5, 34.6, 34.7 (West Supp. 1971).
121. Colo. Rev. Stat. Ann. § 41-2-13 (added by 1971 Session Laws, Chapter 124, S.B. No. 169).
122. Ga. Code Ann. Ch. 88-29 (1971).
123. Ill. Ann. Stat. Ch. 91, §§ 18.1-18.7 (Smith-Hurd 1966 and Supp. 1972).
124. Ky. Rev. Stat. § 214.185 (as revised by S.B. 309, 1972).
125. Md. Ann. Code art. 43, § 135 (1971).
126. S.F. No. 1496, Ch. 544 (1971).
127. Miss. Code Ann. § 7129-81 et seq. (1971 Cum. Supp.).
128. N.C. Gen. Stat. §§ 90-21.1-90-21.5 (as amended 1971).
129. Pa. Stat. tit. 35, §§ 10101-10105 (1969).
130. All except South Carolina, Wisconsin and Wyoming. For citations, see individual state profiles.
131. 1959-60 Opinions of Attorney General of South Carolina 231 (Opin. No. 685, Aug. 5, 1960). A similar opinion has been expressed by the Attorney General of the Virgin Islands. See Virgin Islands profile.
132. N.J. Stat. Ann. § 9:17 A-4 (1971 Cum. Supp.).
133. See discussion in H. F. Pilpel and N. F. Wechsler, "Birth Control, Teen-Agers and the Law: A New Look, 1971," *Family Planning Perspectives*, Vol. 3, No. 3, July 1971, p. 43.
134. P. Cutright, Testimony before the Commission on Population Growth and the American Future, May 27, 1971.
135. Alabama, Alaska (examination only), California, Delaware, Georgia, Hawaii, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, New Jersey, New Mexico (examination and diagnosis), Pennsylvania and Virginia. The District of Columbia also has such a provision. In addition, Alabama, Illinois, Montana and New Jersey laws provide that pregnant minors may consent to all medical and surgical care. For citations, see the individual state profiles below.
136. *Ballard v. Anderson*, 4 Cal. 3d 873, 484 P. 2d 1345 (1971). Three of the statutes providing for medical care of minors related to pregnancy—Georgia's, Kentucky's and Missouri's—specifically exclude abortion. The Delaware statute, on the other hand, specifically authorizes "lawful therapeutic procedures [which] include abortion as permitted under the law of this State and any subsequent amendments thereof."
137. *Ballard v. Anderson*, *supra* note 136.
138. Letter from Attorney General Arthur K. Bolton to Dr. John H. Venable, Director, Georgia Dep't of Public Health, Nov. 3, 1971. In Georgia, however, a new statute authorizes services to minors for the *prevention* of pregnancy without parental consent. See Georgia profile.
139. See footnotes 1 and 2 *supra*.
140. There have been cases where physicians have been found liable for damages for providing medical treatment to a minor younger than 15 (e.g., *Zoski v. Gaines*, *supra* note 1, where the minor was nine years old), or where the treatment was not for the benefit of the minor (e.g., *Zaman v. Schultz*, 19 Pa. D. & C. 309 (1933), involving the donating of blood, and *Bonner v. Moran*, *supra* note 53, involving the donation of a skin graft).
141. *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905), overruled on other grounds, *Benzel v. Halvorson*, 248 Minn. 527, 80 N.W. 2d 854 (1957).
142. See, e.g., Cal. Penal Code § 272 (West 1970); Neb. Rev. Stat. § 28-477 (1956); N.Y. Penal Code § 260.10 (McKinney Cum. Supp. 1971).
143. *Ohio v. McLaughlin*, 4 Ohio App. 2d 327, 212 N.E. 2d 635 (1965).
144. See Ohio profile—Contraception—2. Laws and Court Decisions Relating to Sale and Distribution of Contraceptives.
145. *Richmond Times-Dispatch*, October 30, 1971.
146. *New York Post*, August 7, 1971, p. 3.
147. *Eisenstadt v. Baird*, 40 U.S. Law Week 4303 (March 21, 1972). See discussion in Summary and Analysis of State Laws Relating to Contraception and Massachusetts profile.
148. § 220.21. Family Planning Services.
149. N.Y. Educ. Law § 6811 (McKinney Supp. 1971).
150. Neb. Stat. § 71-1112 (1967).
151. Utah Code Ann. § 58-19-9 (1953).
152. Principles of Medical Ethics of the American Medical Association, Section 9 (1971).
153. See 8 Wigmore, Evidence § 2380 (McNaughton rev. 1961); DeWitt, Privileged Communications Between Physician and Patient, 447 et seq. (1958); Shartel & Plant, The Law of Medical Practice 48-49 (1959); Note, "Legal Protection of the Confidential Nature of the Physician-Patient Relationship," 52 Col. L. Rev. 383 (1952). Many but not all of these laws preclude only disclosures made on a witness stand. Other statutes provide that "betrayal of professional secrets" shall be a ground for revoking a physician's license.
154. See *Munzer v. Blaisdell*, 183 Misc. 773, 49 N.Y.S. 2d 915 (Sup. Ct. N.Y. Co. 1944), aff'd without opinion, 269 App. Div. 970, 58 N.Y.S. 2d 359 (1st Dep't 1945); *Griffin v. Medical Society of State of N.Y.*, 7 Misc. 549, 11 N.Y.S. 2d 109 (Sup. Ct. N.Y. Co. 1939); *Alpin v. Morton*, 21

- Ohio St. 536 (Ohio Sup. Ct. 1871); *Hammonds v. Aetna Casualty & Surety Co.*, 237 F. Supp. 96 (N.D. Ohio 1965), motions overruled, 243 F. Supp. 793 (N.D. Ohio 1965); *Smith v. Driscoll*, 94 Wash. 441, 162 Pac. 572 (1917). But see *Quarles v. Sutherland*, 215 Tenn. 651, 389 S.W. 2d 249 (1965).
155. *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920).
 156. *Hague v. Williams*, 37 N.J. 328, 181 A. 2d 345 (1962); *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S. 2d 564 (Sup. Ct. Kings Co. 1960); *Berry v. Moench*, 8 Utah 2d 191, 331 P. 2d 814 (1958).
 157. *Hague v. Williams*, *supra* note 156, 181 A. 2d at 349.
 158. *Clark v. Geraci*, *supra* note 156, 208 N.Y.S. 2d at 567.
 159. *Pennison v. Provident Life & Accident Ins. Co.*, 154 So. 2d 617 (La. App. 1963), writ refused 244 La. 1019, 156 So. 2d 226 (1963); *Curry v. Corn*, 52 Misc. 2d 1035, 277 N.Y.S. 2d 470 (Sup. Ct. Nassau Co. 1966).
 160. In *Alpin v. Morton*, 21 Ohio St. 536 (Ohio Sup. Ct. 1871), a physician was held liable for slander for having told the mother of an unmarried 16-year-old girl and two other ladies that the girl was pregnant "and that if she was not that she had got rid of it." While the action was pending, the girl died, and damages were ultimately recovered by the mother on behalf of the estate. In *Kenny v. Gurley*, 208 Ala. 623, 95 So. 34 (1923), it was held that a physician who was the medical director of a college had a conditional privilege to advise the parents of a student who was expelled that she had a venereal disease. The lower court had awarded the girl damages for libel, but the Alabama Supreme Court reversed, holding that she could recover only by proving malice on the doctor's part.
 161. Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, Oregon, South Dakota, Tennessee, Vermont and West Virginia. See citations below.
 162. All but Hawaii, Iowa, Nebraska and Vermont.
 163. Arkansas, California, Delaware, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, New Jersey and Oregon.
 164. Hawaii, Iowa, Nebraska and Vermont.
 165. Delaware.
 166. Montana and Missouri.
 167. California, Kentucky, Maryland, Minnesota, Mississippi and Oregon.
 168. Delaware, Montana and New Jersey.
 169. Ky. Rev. Stat. § 214.185 (as amended by S.B. 309 (1972)).
 170. Md. Ann. Code art. 43, § 135 (1971); Ch. 381 [1971] Oregon Laws 551. The Maryland law specifies that the doctor shall not be obligated to inform the parent.
 171. Cal. Civ. Code § 34.6 (West Supp. 1971).
 172. S.F. No. 1496, Ch. 544 § 144.346 (1971).
 173. Miss. Code Ann. § 7129-85 (Cum. Supp. 1971).
 174. Ark. Stat. Ann. § 82-631 (Cum. Supp. 1971); Fla. Stat. Ann. § 384.061 (as amended effective Oct. 1, 1971); Ga. Code Ann. § 74-104.3 (Cum. Supp. 1971); Ill. Ann. Stat. ch. 91, § 18.5 (Smith-Hurd Cum. Supp. 1972); Kan. Stat. Ann. § 65-2892 (Supp. 1970); La. Rev. Stat. § 40:1065.1 (Cum. Supp. 1971); Mich. Comp. Laws Ann. § 329.221 (Cum. Supp. 1972).
 175. All except Illinois. The Florida statute requires the physician to "make a sincere attempt to persuade the minor to permit him to divulge the nature of the condition to the parent or parents of the minor." However, if the attempt fails the physician is empowered to tell the parents anyway.
 176. Colo. Rev. Stat. Ann. § 66-9-2 (4) (Supp. 1967); Maine Rev. Stat. Ann. tit. 32, § 3154 (Cum. Supp. 1972); Miss. Code Ann. § 8893.7 (Cum. Supp. 1971); N.H. Rev. Stat. Ann. § 141:11-a (added by laws of 1972, ch. 11); N.Y. Pub. Health Law § 2305 (McKinney 1971); S. Dak. Comp. Laws § 34-223-17 (Supp. 1971) (limited to doctors attached to state and county health departments); Tenn. Code Ann. § 53-1104 (Cum. Supp. 1971); W. Va. Code Ann. § 16-4-10 (Cum. Supp. 1972).
 177. Iowa Code Ann. § 140.9 (1972). But a doctor may not disclose to a parent the fact that his child is being treated for drug addiction. Iowa Code Ann. § 224 A.2 (Cum. Supp. 1972).
 178. Neb. Rev. Stat. § 1120 (1967).
 179. Vt. Stat. Ann. tit. 18, § 4226 (Cum. Supp. 1971).
 180. Hawaii Rev. Laws § 577A-3 (Supp. 1971).
 181. Mo. Rev. Stat. § 431.062 (1971 Supp.).
 182. Del. Code Ann. tit. 13, § 708 (Cum. Supp. 1970).
 183. N.J. Stat. Ann. § 9:17A-5 (Supp. 1971).
 184. Mont. Rev. Codes § 69-6102 (1970).
 185. 381 U.S. 479 (1965).
 186. *People v. Belous*, 71 Cal. 2d 954, 80 Cal. Reprtr. 354, 458 P. 2d 194 (Sup. Ct. Cal. 1969), *cert. denied* 397 U.S. 915 (1970).
 187. *Doe v. Scott*, 321 F. Supp. 1385 (N.D. Ill. 1971); *Roe v. Wade*, 314 F. Supp. 1217 (N.D. Tex. 1970).
 188. 40 U.S. Law Week 4303 (March 21, 1972).
 189. See dissenting opinion of Justice William O. Douglas in *Wisconsin v. Yoder*, U.S. Supreme Court No. 70-110, May 15, 1972.
 190. In re Gault, 387 U.S. 1 (1967); In re Winship, 397 U.S. 358 (1970).
 191. *Tinker v. Des Moines Community School*, 393 U.S. 503 (1969).
 192. *Id.* at 511.
 193. *Olf v. East Side Union High School District*, 445 F. 2d 932 (9th Cir. 1971), *cert. denied* 40 U.S. Law Week 3332 (1/18/72); *Jackson v. Dorrier*, 424 F. 2d 213 (6th Cir. 1970), *cert. denied*, 400 U.S. 850 (1970).
 194. *Breen v. Kahl*, 419 F. 2d 1034 (7th Cir. 1969), *cert. denied*, 398 U.S. 937 (1970).
 195. See cases cited in footnote 5 to Justice Douglas's dissenting opinion in *Olf v. East Side Union High School District*, 40 U.S. Law Week 3332 (1/18/72) and in Note, 84 Harv. L. Rev. 1702, 1703 n. 4 (1971). See also Justice Douglas's dissenting opinion in *Wisconsin v. Yoder*, *supra* note 189.
 196. *Richards v. Thurston*, 424 F. 2d 1281 at 1285 (1st Cir. 1970), quoting from *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).
 197. *Jane Doe et al v. Planned Parenthood Association of Utah*, District Court of Salt Lake County No. 204803, Memorandum Decision by Judge Hanson, May 15, 1972.
 198. Cal. Welf. & Inst'ns. Code § 10053.2 (1971).

Summary and Analysis of State Health and Welfare Department Policies on Family Planning and Voluntary Sterilization

General Characteristics

Most of the 50 states and five federal jurisdictions¹ included in this study have some type of official, written policy regarding family planning services in both their health and welfare agencies. Most of these agencies have more than one policy document. Fifty states and three federal jurisdictions have a written welfare policy on family planning.² Health agencies in 10 states appeared not to have had any type of written health policy on family planning as of September 1, 1971.³ Information on health policies in American Samoa was not available.

More than half of the 40 health agencies with family planning policies for which the date of promulgation or revision is known have revised these policies and/or adopted new policies within the past two years (see Tables 16 and 17).

The dates of adoption or revision of welfare family planning policies are even more compressed in time, and are clearly associated with the passage of the 1967 Amendments to Title IV-A of the Social Security Act (SSA),⁴ (see Tables 16 and 18). Only three states, Alaska, Kansas and Nevada, have not effected any revision of these policies since 1967. It is significant that nearly one-third of all states and federal jurisdictions adopted some type of welfare family planning policy revision in 1971 (see Table 16). Apparently the 1967 Amendments affected state welfare agency policy formation, not only in the two years following adoption of the Amendments and the promulgation of federal regulations, but as recently as last year.

State policies on family planning vary considerably in scope from one or two paragraph statements of objectives to detailed policy and procedure manuals or handbooks which include specifications for referral and clinic operations. In general, welfare policies on family planning are more systematically organized and incorporated into other policy materials such as social service manuals and handbooks with specific numerical designations than are health policies, which are rarely identified so precisely; more often health policies on family planning are found in isolated documents, such as statements of overall purpose or goals, which do not refer to pro-

gram implementation and which are not integrated systematically into other health policy materials. The more recent health policy issuances tend to be more comprehensive and detailed than earlier ones.⁵

In interpreting state health and welfare policies it is important to recognize that the two types of agencies are in part governed and influenced by different federal laws and contrasting traditions and approaches to services.

Federally authorized programs operated by state health agencies are commonly defined in terms of specific categories of health needs, conditions, or problems. For example, the Maternal and Child Health (MCH) programs authorized by Title V of the Social Security Act are intended to serve certain health needs of pregnant women, of women who have recently delivered, and of their newborn children. Similarly, the Crippled Children's programs, also authorized by Title V, are related to certain health needs of crippled children.

Most federally authorized health programs define specifically the kinds of health problems they seek to prevent or alleviate; but these programs are not generally defined in terms of specific categories of eligibility based on personal or family income or other social characteristics. In addition, public health agencies traditionally protect the public health through the provision of certain environment health services and through the supplementation of personal health services available locally through the private sector. Such categorical health programs are intended generally to reach the broadest possible spectrum of those who evidence a designated health need and who are not likely to be able to obtain the appropriate health care through the private sector.

State welfare agencies, on the other hand, are primarily responsible for the administration of money payments to individuals and families which meet specific economic and social eligibility standards defined in federal law. For example, the Aid to Families with Dependent Children (AFDC) program employs eligibility criteria related to income and family structure which are determined by the Social Security Act. Similarly, the Aid to the Blind

Table 16. State Health and Welfare Policies on Family Planning Promulgated or Revised 1962-1971

Date of Most Recent Policy or Policy Revision	Health Policies	Welfare Policies	Date of Most Recent Policy or Policy Revision	Health Policies	Welfare Policies
1962	Virginia		1970	Alabama	Arkansas
1965	Delaware			Arkansas	California
	Georgia			Florida	Colorado
	Hawaii		Mississippi	Hawaii	
	Kansas		New Hampshire	Indiana	
	Minnesota		New York	Maryland	
	Montana		Oregon	Michigan	
	Nevada		South Carolina	Missouri	
	Utah		Virgin Islands	Nebraska	
			West Virginia	New Mexico	
1966	Alaska	Alaska		Rhode Island	
	Indiana	Kansas		Texas	
	Maine			Virgin Islands	
1967	Massachusetts	Nevada	1971	Arizona	Arizona
1968	California	Connecticut		Dist. of Columbia	Delaware
	Connecticut	Florida		Illinois	Dist. of Columbia
		North Dakota		Kentucky	Georgia
		South Dakota		Maryland	Idaho
				New Jersey	Illinois
				North Dakota	Louisiana
				Ohio	Minnesota
				Pennsylvania	New York
				Puerto Rico	Ohio
			Tennessee	Oregon	
1969	Louisiana	Iowa	Washington	Utah	
	Michigan	Kentucky		Virginia	
	Oklahoma	Maine		Washington	
		Massachusetts		Wisconsin	
		Mississippi			
		Montana			
		New Hampshire			
		New Jersey			
		North Carolina			
		Oklahoma			
	Pennsylvania				
	South Carolina				
	Tennessee				
	Vermont				
	West Virginia				
			TOTAL	40	50

* This includes policies for which the date of promulgation or revision is known for all states and federal jurisdictions which have such policies, as of September 1971.

(AB) and the Aid to the Permanently and Totally Disabled (APTD) programs provide cash assistance to persons who qualify under specific program standards. Thus, 'means tests' are a central feature of state-administered welfare programs. Supportive social services are provided, either directly or indirectly, by welfare departments to persons eligible for these federally aided assistance programs. Such persons are also eligible under federal law for Medicaid, the basic federally aided medical assistance program for the indigent. Supportive social and medical services are provided to persons eligible for financial assistance to help eliminate, or at least ameliorate, the causes of economic dependency. The

basis for determining eligibility for state welfare programs, therefore, is largely established in federal law; and these federally authorized programs of cash assistance and ancillary social and medical services are generally defined in terms of such eligibility categories.

Welfare agencies have traditionally acted as intermediaries between the welfare recipient and the service providers, determining the service needs of recipients through counseling and casework and making the necessary referrals to providers. For the most part, the welfare agencies have relied on available free community resources for services. However, since 1968, welfare departments have been re-

Table 17.

Current Health Policies On Family Planning

State	Identification of Policy	Issuing Agency (Unit)	Date
Alabama	Recommendations	State Board of Health	April, August 1970
Alaska	Policy Statement on Family Planning	Department of Health and Social Services	July 5, 1966
Arizona	Policy Statement	Board of Health	Jan. 15, 1971
Arkansas	Family Planning Manual	Dept. of Health	Dec. 1970
California	California State Administrative Code Title XVII, No. 1276		1966
	Suggested Standards and Recommendations for Public Family Planning	Bureau Maternal and Child Health	1968
Colorado	(No written policy)		
Connecticut	Policy Statement: Responsible Parenthood	Connecticut State Dept. of Health	June 13, 1968
	Circular Letter #37	Dept. of Health	Sept. 30, 1968
Delaware	Policy Statement: Policy on Family Planning	Delaware State Board of Health	Mar. 25, 1965
District of Columbia	Policies and Procedure Manual	Department of Public Health	July 1966
	Regulations governing the provision of contraceptive information services and devices to minors	Dept. of Public Health	Aug. 1971
Florida	Standards and operating procedures for family planning services*	Florida Division of Health	Feb. 1965
Georgia	Program Manual: Policy and Procedures	State Dept. of Health	June 1965
Guam	Statement regarding the family planning program	Maternal and Child Health Services, Department of Public Health	Undated
Hawaii	Policy statement on family planning	Dept. of Health	1965
Idaho	Policy statement approving the state health agency's family planning program	State Board of Health	Undated
	Guidelines for determining financial eligibility	Crippled Children Service, Depart. of Public Health	Dec. 1966
Illinois	Policy statement on family planning	Dept. of Public Health	June 1968
	Revised guidelines for family planning grants	Div. of Family Health, Depart. of Public Health	March 1971
Indiana	Indiana State Board of Health Policy Statement on family planning programs	State Board of Health	Nov. 9, 1966
Iowa	(No written policy)		
Kansas	Board Policy Statement Family Planning—Senate Bill 23	Dept. of Health	Apr. 30, 1965
Kentucky	Policy Statement	State Health Dept.	1966
	Standards and Procedures—family planning services and clinics—guide for local health depts.	State Health Dept.	1971

* An additional preface to the standards was issued in January 1970.

Table 17 (Continued).

Current Health Policies On Family Planning

State	Identification of Policy	Issuing Agency (Unit)	Date
Louisiana	Resolution Resolution Joint Memorandum	State Board of Health State Board of Health State Health Dept. and La. family planning program	July 23, 1965 Nov. 4, 1967 Dec. 17, 1969
Maine	Statement of policy and procedure on family planning	Dept. of Health and Welfare	Dec. 1966
Maryland	Policy Statement on family planning	State Board of Health and Mental Hygiene	June 22, 1966
	Family planning services guide for local health depts. Memorandum	Div. of Maternal and Child Health, Dept. of Health Div. of Maternal and Child Health, Dept. of Health	Nov. 19, 1970 1971
Massachusetts	Policy statement on family planning Consortium statement	Dept. of Public Health Dept. of Public Health	June 1967 Undated
Michigan	Notice of Rule-making: Family Planning Services Plan 1970-71, preventive services program, family planning subprogram	Dept. of Public Health Dept. of Public Health	1965 1969
Minnesota	Statement of policy on family planning	State Board of Health	July 1965
Mississippi	Family Planning (Draft policy)	State Board of Health	October 1970
Missouri	(No written policy)		
Montana	Policy statement on family planning	State Board of Health	Jan. 9, 1965
Nebraska	(No written policy)		
Nevada	Policy statement: Birth Control Program (State Division of Health Policies, amdt. of Chapter II, MCH)	Div. of Health	May 1965
New Hampshire	Family Planning Program Policy and Procedure Manual	Bureau of Maternal and Child Health, Dept. of Health and Welfare	May 1970
New Jersey	Personnel and program standards manual Standards for family planning services	State Dept. of Health Dept. of Health	revised Oct. 1970 Jan. 1971
New Mexico	(No written policy)		
New York State	Executive Memorandum 69-10 Field Memorandum 69-114 Field Memorandum 70-70	Dept. of Health Dept. of Health Dept. of Health	March 5, 1969 Oct. 15, 1969 Sept. 15, 1970
North Carolina	Recommended guidelines for setting up family planning clinics Proposed North Carolina family planning program (Supplemental Section C), clinical standards for contraceptive service	Board of Health Board of Health	Undated Undated
North Dakota	Statement of policy regarding family planning	Dept. of Health	July 28, 1971
Ohio	State guidelines for family planning	Div. of Maternal and Child Health, Dept. of Health	May 1971

Table 17 (Continued).

Current Health Policies On Family Planning

State	Identification of Policy	Issuing Agency (Unit)	Date
Oklahoma	Policy statement: family planning Guidelines for family planning programs	State Board of Health Maternal and Child Health, Department of Health	Dec. 1967 June 1969
Oregon	Resolution on family planning Availability of services	State Board of Health Maternal and Child Health Section, Board of Health	Undated Undated
	Guidelines for family planning clinics	Family Planning program	July 1970
Pennsylvania	Statement Guidelines and instructions for preparing and submitting service contract applications Memorandum	Pa. Advisory Health Board Div. of Maternal and Child Health, Dept. of Health Acting Secretary of Health	Aug. 17, 1965 Jan. 1971 Aug. 6, 1969
Puerto Rico	Population and family planning report Governor's annual State of the Commonwealth speech Proposal for Island wide family planning program Continuation Application, family planning project No. 758	Governor's Advisory Council Governor Dept. of Health Dept. of Health	Nov. 1969 Jan. 1970 Apr. 1970 Apr. 1971
Rhode Island	State Plan Chpt 11, Mat. & Child Health	Department of Health	Not Available
American Samoa	Policy Not Available		
South Carolina	Policy statement: Recommendations and Policies for Family Planning Clinics Memorandum: Suggested definitions for use in family planning programs	State Board of Health Bureau of Maternal and Child Health, Dept. of Health	Dec. 1970 Jan. 1970
South Dakota	(No written policy)		
Tennessee	Special letter and Rules and Regulations of the Family Planning Act of 1971	Commissioner of Public Health	Sept. 14, 1971
Texas	(No written policy)		
Utah	Policy statement on family planning	State Board of Health	June 16, 1965
Vermont	(No written policy)		
Virginia	Letter regarding Policy relative to Planned Parenthood Services	Commissioner of Health Department of Health	June 18, 1962
Virgin Islands	Family Planning Manual	Department of Health	Sept. 1970
Washington	Policy regarding family planning Program (WAC 248-128-001) Guidelines and minimum requirements for local family planning program proposals	Div. of Health Office of Health Services, Div. of Health	July 1, 1968 Jan. 1971
West Virginia	Operational procedures manual for family planning and child spacing clinics	State Health Dept.	Aug. 1970
Wisconsin	(No written policy)		
Wyoming	(No written policy)		

quired by federal law to purchase certain supportive social and medical services, including family planning services, for current welfare recipients when there are no free community services or they are inadequate. With respect to any given social or medical service, then, the welfare agency may act in its traditional role as a referral agency only, in which case it has only limited responsibility for insuring that the service is provided to the recipient; or it may act as both a referral agent *and* as a purchaser of the service. As observed in the 1970 City University of New York (CUNY) survey of state and local welfare departments and the 1971 Center for Family Planning Program Development (CFPPD) survey of state welfare and health departments (see Methodology Section for descriptions of these surveys), this distinction between the referral and purchase activities of welfare agencies contributes to an apparent pattern of eligibility requirements for ancillary services: *Eligibility for purchased services* (family planning in this case) is associated with the welfare agency's commitment of funds to secure services, and is ordinarily determined in terms of the federally defined categories of eligibility, as set forth in the Social Security Act. *Eligibility for referral* to family planning services, however, was observed in the CFPPD study to include additional groups, such as past and potential recipients of cash assistance and residents of low-income areas.

There is a significant contrast, then, between federally authorized health and welfare programs: Health programs are generally intended by law to serve a broad segment of the public which has a specific health need or problem; welfare programs are intended to serve legislatively determined categories of economically dependent persons who must meet rigorous eligibility criteria in order to receive money payments and services. This results in differing approaches by health and welfare agencies to the issue of eligibility. As observed in the CFPPD survey, health agencies have considerable latitude in setting eligibility standards for family planning services. Therefore, their eligibility standards for family planning are generally quite flexible at the state level; eligibility determination is often left to more local jurisdictions. This situation may or may not contribute to a more restrictive eligibility policy at the service delivery level.

Welfare agencies, on the other hand, have fairly rigid, largely federally determined eligibility requirements for their programs of cash assistance, social services, and medical benefits. For example, it was observed in the CFPPD study that eligibility for family planning services which are *purchased* by the welfare agency is defined in terms of such federally defined categories as AFDC, APTD and AB.

In the following discussion of state policies on eligibility, financing, administration, and voluntary

sterilization services it should be kept in mind that the sources of information are varied. Primary reliance is placed on the official, written policy documents promulgated by state agencies (see Tables 17 and 18). However, additional supplementary sources of policy information were used in this study, such as the CUNY study, the 1970 National Center for Family Planning Services (NCFPS) letter inquiry of state health agencies, and the CFPPD survey (see Methodology Section). Where apparent conflicts arose between different sources of policy information, the written policies were considered the more authoritative source. In the absence of official documents, however, the supplementary sources provided a useful view of state policy.

Eligibility Requirements and Patient Fees

Health and welfare agency policies regarding eligibility for family planning services differ in two respects:

- Health policies tend to be less formal and less consistent in their coverage of eligibility requirements than welfare policies. All 50 states, and the three federal jurisdictions which had welfare programs about which information was available for this study (District of Columbia, Puerto Rico and the Virgin Islands),⁶ had policies on eligibility for family planning services. However, there were at least 13 states which had no corresponding health department policy;⁷ no health policy information was available for American Samoa. At the same time, there were only 10 state health agencies which dealt with all three categories of eligibility requirements selected for study here—financial, social, and geographical.⁸
- Health department policies on eligibility for family planning also tend to be more flexible and less restrictive than welfare department policies. As noted above, welfare agencies employ the rigorous eligibility standards of categorical welfare programs which are dictated by federal law. Health agencies, on the other hand, without any specific federal mandate regarding eligibility, tend to be guided by state statutes or to leave eligibility determination to local jurisdictions.

Income and Income-Related Criteria for Eligibility and Patient Fees

Health Agencies: 28 health agencies of state and federal jurisdictions have no specific financial eligibility policies for family planning services; no information was available for American Samoa⁹ (see Tables 19 and 20). Of the 26 states and jurisdictions which have such policies, 10 states,¹⁰ the District of Columbia and the Virgin Islands either recommend against or prohibit the use of income limitations on eligibility. Fourteen health agencies, however, recom-

Table 18.

Current Welfare Policies on Family Planning

State	Identification of Policy	Issuing Agency (Unit)	Date
Alabama	Manual for Administration of Service for Children and Their Families, Section C	Dept. of Pensions and Security	Undated
Alaska	Public Welfare Staff Manual, Section 3500	Division of Social Services	September 1966
Arizona	Child Welfare Manual, Chapter XIII, Sections 4-1300 thru 4-1307	Dept. of Public Welfare	April 1969 May 1971
Arkansas	Public Welfare Manual, Sections 4440 and 4450	Dept. of Public Welfare	January 1970
	State Plan Service Programs for Families and Children, Section 3.7		July 1969
California	Public Social Services Manual, Chapter 30-450	Dept. of Social Welfare	January 1970
Colorado	Public Welfare Staff Manual, Vol. VII, Sections A-7410.22, A-7460 and C-7032	Division of Public Welfare	January 1970 December 1968
Connecticut	Departmental Bulletins 2124 and 2111.	Welfare Department	July 1968 May 1968
	Commissioner's Memorandum		February 1967
Delaware	Policy Manual of Services to Families and Children, Section 2315 and 7115.	Division of Social Services	January 1970 January 1971
	Vendor Payments Manual, Section 1005		July 1970
District of Columbia	Handbook Release 152	Social Services Administration	June 1968
	Commissioner's Administrative Instructions	Commissioner (Mayor)	September 1971
Florida	Division of Family Services Manual, Chapter 600	Division of Family Services	June 1968 April 1968
	Operations Letter No. 1623		
Georgia	County Letters 164, 190, and 326.	Department of Family and Children Services	February 1968 May 1968
	Director's Memo on family planning. Inter-agency agreement with the Health Department		September 1971 March 1971 July 1971
Guam	No response		
Hawaii	Department of Social Services Manual, Section 3449 and Sections 5040-5043	Dept. of Social Services	June 1967 September 1970
Idaho	Operating Policies & Procedures Manual, Sections 3060 and 3061	Dept. of Public Assistance	October 1971
Illinois	Department of Public Aid Manual, Sections 5104.5 and 6126	Dept. of Public Aid	March 1970 September 1971
Indiana	General Administrative Bulletin No. 66	Dept. of Public Welfare	April 1970 August 1969
	Families and Children Manual, Vol. III, Section H		
Iowa	Employees' Manual, Chapter VII-II. A memorandum to County Medical Committees	Dept. of Social Services	October 1969 September 1965
Kansas	Directive L-464 to County Welfare Directors.	Dept. of Social Welfare	June 1965
	Memorandum to Physicians Serving Kansas Welfare Recipients		June 1966
Kentucky	Manual of Operation, Section 6118	Dept. of Economic Security	May 1969

Table 18 (Continued).

Current Welfare Policies on Family Planning

State	Identification of Policy	Issuing Agency (Unit)	Date
Louisiana	Manual for Services for Families and Children, Chapter XII, Part VII.	Dept. of Public Welfare	November 1970
Maine	Contract with Family Planning, Inc. Public Assistance Manual, Chapter III. State Plan of Service Programs for Families and Children, Section 3.7	Bureau of Social Welfare	July 1971 March 1966 April 1969
Maryland	Rule 100, Family Planning Services. Rule 300, Single Parent Services. Program Manual, Section P-00-k	Dept. of Employment and Social Services	July 1968 September 1970 Undated
Massachusetts	State Plan of Service Programs for Families and Children, Section 3.7 Family Planning Services	Dept. of Public Welfare	July 1969
Michigan	Department of Social Services Manual, Item A-110. Social Services Rules. Section R400.14	Dept. of Social Services	October 1970 Undated
Minnesota	Public Welfare Manual, Part VII. Sections 3158.05 thru 3158.056. Departmental Regulations, Chapter 30-450	Dept. of Public Welfare	March 1971 Undated
Mississippi	Public Welfare Manual, Volume IV, Page 1054	Dept. of Public Welfare	July 1969
Missouri	Public Assistance Manual, Volume II, Section XIX. Family Service Manual, Chapter VII	Division of Welfare	May 1969 February 1970 July 1970
Montana	Public Welfare Manual, Volume II, Section 2950	Dept. of Public Welfare	July 1969
Nebraska	State Plan and Manual, Sections 1520, 1536, 1771, and 6532	Dept. of Public Welfare	September 1970 July 1970
Nevada	Welfare Division Manual, Pages 2, 6, 20, and 21. Manual of Dept. of Health, Welfare & Rehabilitation, Section 2-06-063. Staff Memorandum No. 42.	Dept. of Health, Welfare & Rehabilitation	Undated December 1967
New Hampshire	Division of Welfare Manual, Sections 9950-9965.	Division of Welfare	July 1965 August 1969
New Jersey	Circular Letter No. 538 Circular Letter No. 583	Division of Public Welfare	October 1968 January 1969
New Mexico	Medical Assistance Manual, Section 303.2	Health and Social Services Dept.	January 1970
New York	Dept. of Social Services Regulations, Section 386.16 Administrative Letter No. PWD-82	Dept. of Social Services	September 1971
North Carolina	Manual of the Welfare Program Divisions, Volume I, Chapter VII, Sections 1400-1404 Supplement No. 9 to County Letter 193 Inter-agency agreement with the Dept. of Health	Dept. of Social Services	December 1969 Undated (1969)
North Dakota	Social Work Manual, Chapter 319, Section 9	Dept. of Social Services	February 1968
Ohio	Social Services Manual, Chapter 30, Section 32.2 Public Assistance Manual Sections 722.4 and 751.1	Dept. of Public Welfare	July 1971 Undated

Table 18 (Continued).

Current Welfare Policies on Family Planning

State	Identification of Policy	Issuing Agency (Unit)	Date
Oklahoma	Policy and Procedure Manual, Section 625	Dept. of Institutions, Social and Rehabilitative Services	May 1969
Oregon	Executive Bulletin 69-19. Revision No. 2 to Pharmaceutical Services, Guide for Public Welfare Medical Services, Page B-1	Public Welfare Division	March 1969 July 1971
Pennsylvania	Memorandum No. 870, Supplement. No. 3 State Plan of Service Program for Families and Children, Section 3.7	Dept. of Public Welfare	January 1968 May 1969
Puerto Rico	No Written Policy		
Rhode Island	Public Assistance Service Manual, Chapter 1, Section 100.2 Family Manual, Section 27	Dept. of Social and Rehabilitative Services	December 1969 October 1970
Samoa	No Welfare Program		
South Carolina	State Plan of Service Programs for Families and Children, Section 3.7	Dept. of Public Welfare	May 1969
South Dakota	Public Welfare Manual, Chapter 10-C	Dept. of Public Welfare	November 1968
Tennessee	Bulletin No. 72 Public Welfare Manual, Volume IV, Chapter XII.	Dept. of Public Welfare Dept. of Public Welfare	February 1969 February 1969
Texas	Social Services Handbook, Sections-4300 thru 4340	Dept. of Public Welfare	November 1970
Utah	Social Services Manual, Section 4670 Division of Family Services Manual, Sections T-4135 and 5424 Opinion No. 71-017	Dept. of Social Services Utah Attorney General	November 1968 March 1970 August 1969 July 1971
Vermont	Two Commissioners' Memoranda Social Welfare Bulletin No. 69-20	Dept. of Social Welfare	November 1967 January 1969
Virginia	Guide material, Family Planning Services Bulletin No. 477 and 464 General Release to Superintendents of Welfare	Dept. of Welfare and Institutions	July 1970 Sept. 1968 - June 1969 May 1971
Virgin Islands	Family Planning, Proposal—Welfare contributions	Insular Dept. of Social Welfare	July 1970
Washington	Administrative Code, Section 388-16-115 Public Assistance Manual H, Sections 58.24 and 58.52. State Plan of Service Programs for Families and Children, Section 3.7	Dept. of Social and Health Services	Undated Undated January 1971
West Virginia	Social Services Manual, Section 8000 thru 8050	Dept. of Welfare	July 1969
Wisconsin	State Plan of Service Programs for Families and Children, Section 3.7, Family Planning Services. Guidelines for Developing Manual Instructions	Dept. of Health and Social Services	May 1969 August 1971
Wyoming	Division of Public Assistance and Social Services Manual, Volume III. Section 430 and 431 and Volume I, Section 230	Division of Public Assistance and Social Services	Undated Undated

Table 19.**State Health Agencies-Eligibility and Patient Fee Policies on Family Planning**

State Health Policies Which Establish or Recommend Eligibility Restrictions or Patient Fees: *

Authority	Eligibility			Patient Fees
	Financial	Social	Geographical	
Established by State Health Agency	Idaho Maine Michigan Mississippi** New Hampshire Oklahoma Oregon Pennsylvania	Alaska Delaware Florida Guam Hawaii Idaho Kansas Oklahoma Texas Utah# Virgin Islands	Colorado# Mississippi** Oregon Texas# Utah#	
Recommended by State Health Agency	Alabama Colorado# Florida Minnesota Nevada West Virginia	Arizona Arkansas Kentucky Louisiana Maine Missouri# Montana# Nevada North Carolina Puerto Rico# Rhode Island# South Dakota#	Florida Tennessee	Colorado#

State Health Policies Which Prohibit or Recommend Against Eligibility Restrictions or Patient Fees: *

Established by State Health Agency	Ohio Virgin Islands	Georgia Michigan Mississippi** Oregon New Hampshire West Virginia	New Hampshire	California Guam Mississippi** New Hampshire
Recommended by State Health Agency	Arizona California Dist. of Columbia Kentucky Maryland North Carolina Rhode Island# South Carolina Tennessee	Alabama California Colorado# Dist. of Columbia Illinois Maryland Ohio South Carolina Tennessee Virginia Washington#	California Maryland Rhode Island# West Virginia	Dist. of Columbia Rhode Island South Carolina Tennessee West Virginia

* States appearing under one heading do not appear necessarily under all headings: few states recommend or establish all types of eligibility requirements or patient fees.

** Information on Mississippi health agency policy is from the 1970 NCFPS letter inquiry. The information has not been verified more recently; the policy material is undated.

The following states neither recommend nor establish any specific eligibility requirements or patient fees; these states indicate that such policies are determined by local agencies: Connecticut, Indiana, Iowa, Massachusetts, Nebraska, New Jersey, New Mexico, New York, North Dakota, Vermont, Wisconsin, and Wyoming. No information is available for American Samoa.

The eligibility requirements indicated here were reported by the health agency in the 1971 CFPPD survey; however, the health agency did not indicate whether these requirements were established by or recommended in official agency policies, nor were these requirements stated in available written policies. While some health agencies do not have official eligibility policies, they nevertheless recognize and abide by policies and laws otherwise established. These may represent "unofficial" or "unwritten" policies of the health agency or interpretations of relevant statutes.

mend or establish *some* type of financial eligibility requirement (see Table 19); of these 14 agencies, 10 restrict eligibility to the poor or medically indigent,¹¹ and four agencies (Colorado, Idaho, Minnesota and Oregon) recommend or establish a specific income standard.

Most state health policies on family planning either do not mention patient fees or observe that fees are not charged in local facilities. Seven states (California, Mississippi, New Hampshire, Rhode Island, South Carolina, Tennessee and West Virginia), D.C. and Guam either recommend against or prohibit patient fees in local health department family planning programs. Only one state health agency, Colorado's, recommends that patients be charged for family planning on a sliding fee scale.¹²

Welfare Agencies: As noted above, income-related criteria ('means tests') form the basis for individual and family eligibility under the various federally aided welfare programs (AFDC, APTD and AB). Under mandatory provisions of Title IV-A of the SSA, which is the federal law governing the AFDC program, all current AFDC recipients are eligible for medical, social and educational family planning services, and welfare agencies are required to purchase these services in areas where free public or private services are inadequate or nonexistent. Title IV-A also contains optional provisions that permit the states to expand eligibility coverage to include applicants for financial assistance, past recipients, potential recipients and residents of low-income areas.

State welfare agencies generally distinguish between eligibility for *referral to* family planning service sources and eligibility for family planning services *purchased* by the welfare agency as noted above.

According to the CFPPD survey, all states and federal jurisdictions except Alabama, Alaska, Arkansas, Mississippi, Puerto Rico, Tennessee, and the Virgin Islands, *purchase* family planning services for some or all current recipients of AFDC, APTD, and AB; Louisiana limits purchases to applicants for and recipients of AFDC, and Delaware excludes APTD recipients (see Table 21). No information is available for Guam; Samoa does not have a welfare program. But only about half the states have eligibility policies that include current recipients of General Assistance (GA). (GA programs do not receive federal funds and in many states GA is a local welfare program with no state participation.) Ohio and Pennsylvania are the only states which have policies permitting the purchase of services on behalf of current recipients, applicants, past recipients, and potential recipients of federally aided assistance as well as for residents of low-income areas. All of these groups except past recipients are eligible for family planning services in Indiana and Massachusetts; and Hawaii includes all groups except potential recipi-

ents. New Jersey covers past and potential recipients and applicants for AFDC only.

Thirty-five welfare agencies of states and federal jurisdiction *refer* all categories of welfare recipients and related groups, including current recipients of federally aided welfare programs, GA recipients, applicants, past recipients, potential recipients, and residents of low-income areas, for family planning services;¹³ 12 states refer all groups except GA recipients;¹⁴ California refers all groups except GA recipients and residents of low-income areas: Kentucky and Vermont refer recipients of AFDC, APTD and AB only (although Vermont has some responsibility for the administration of GA in that state); Maryland refers all groups except residents of low-income areas; New Jersey refers all groups, but no information is available regarding the coverage of residents of low-income areas; no information is available for Oklahoma on the coverage of optional groups; no information is available on the welfare program in Guam; American Samoa has no welfare program.

Social Criteria for Eligibility: Adults

Of the 54 health agencies of states and federal jurisdictions for which some family planning policy information was available for this study, 37 have no social limitations on the eligibility for adults; 14 leave the determination of social eligibility to local agencies, neither approving nor prohibiting such requirements;¹⁵ only Alaska, Kansas and Guam establish social eligibility restrictions (Table 22).

As indicated above, federal regulations under the Social Security Act (S.S.A.) are mandatory on states and federal jurisdiction with respect to the definition of eligibility categories for welfare-administered family planning services. The regulations under Title IV-A state that family planning services "must be available without regard to marital status, age, or parenthood."

Consistent with the federal mandate, 45 welfare agencies of states and federal jurisdictions place no social limitations on the eligibility of adults for family planning services (see Table 22). Alaska requires unmarried adults to request such service in writing as a condition of eligibility; in Massachusetts and Wisconsin only married adults are eligible. In Connecticut, only AFDC recipients who "are the head of a family" are eligible; and Louisiana, Maryland, Missouri, and Rhode Island require adults to have one or more children to be eligible. (Since the AFDC program is based on the existence of a dependent child, those state policies which require adults to have children or to be "head of a family" to be eligible for services are not inconsistent with the program framework of AFDC.) No information is available on the welfare program in Guam; Samoa has no welfare program.

Table 20.

Income Criteria for Eligibility for Family Planning Services as Recommended
or Established in State Health Policies

State	None	Poor, indigent or medically indigent	Specific income standard	Everyone in need "for any reason"	State	None	Poor, indigent or medically indigent	Specific income standard	Everyone in need "for any reason"
Alabama		X			Nebraska	X			
Alaska	X ¹				Nevada		X ⁸		
Arizona				X	New Hampshire		X ⁹		
Arkansas	X				New Jersey	X			
California				X	New Mexico	X			
Colorado*			X ²		New York	X			
Connecticut	X				North Carolina				X
Delaware	X				North Dakota	X			
District of Columbia				X ³	Ohio				X
Florida		X			Oklahoma		X ¹⁰		
Georgia	X				Oregon			X ¹¹	
Guam	X				Pennsylvania		X ¹²		
Hawaii	X				Puerto Rico	X ¹³			
Idaho			X ⁴		Rhode Island				X
Illinois	X				American Samoa	(Policy unavailable)			
Indiana	X				South Carolina				X
Iowa	X				South Dakota	X			
Kansas	X				Tennessee				X
Kentucky				X	Texas	X			
Louisiana	X				Utah	X			
Maine		X ⁵			Vermont	X			
Maryland				X	Virginia	X			
Massachusetts	X				Virgin Islands				X
Michigan		X			Washington				X
Minnesota			X ⁶		West Virginia		X ¹⁴		
Mississippi		X ⁷			Wisconsin	X			
Missouri	X				Wyoming*	X			
Montana	X				U.S. Total	28	10	4	12

¹ Federal standards apply in the family planning project funded by Department of Health, Education and Welfare in Juneau; no other standards are established or recommended.

² Although the State makes no requirements regarding financial eligibility, the health agency recommends the use of "financial eligibility guide" from the State's Handicapped Children's Program as a guide to localities which choose to use it. The guide is very similar to Federal standards for Crippled Children's Programs.

³ Although the District does not impose income restrictions for eligibility, priority is accorded to low income groups in the medical "high risk" category.

⁴ Federal standards for Crippled Children's Programs.

⁵ "We utilize those (eligibility) requirements established by the National Center for Family Planning Services" Department of Health, Education, and Welfare, according to the state health agency.

⁶ Federal standards for Crippled Children's Programs.

⁷ Eligibility for services will be determined through a process of self certification of medical indigency . . ." (draft guidelines, "Family Planning").

⁸ The Nevada Division of Health recommends that family planning services be provided to medically indigent persons and to those who demonstrate "a need and who insist that they cannot obtain the services elsewhere." Priority is accorded to welfare recipients.

⁹ Maximum annual income of \$5,000 for a family of four (similar to Federal Standards for Crippled Children's program); other persons are eligible who cannot obtain "comparable services . . . for other reasons beyond their control . . ."

¹⁰ "Those applicants financially able to pay will be encouraged to seek service from private physicians or clinics." (State Department of Health Policy Statement, December 1967).

¹¹ Aggregate family income of \$6,000. This is similar to Federal standards for Crippled Children's Programs.

¹² Projects serving the poor receive funding priority from the state health agency in distributing MCH formula grant funds to local agencies.

¹³ Federal standards apply in the island-wide program funded by Department of Health, Education and Welfare.

¹⁴ Persons able to pay for services are referred to private physicians.

* Although the state does not have a formal, written family planning policy, evidence of a policy on financial eligibility requirements for family planning services was taken from the 1971 CFPPD survey.

Table 21.

Groups for Which Welfare Departments Purchase Medical Family Planning Services*

State	Recipients of AFDC, APTD, AB, and GA **	Applicants for Assistance	Past Recipients	Potential Recipients	Residents of Low-Income Areas
Alabama	No	No	No	No	No
Alaska	No ¹	No	No	No	No
Arizona	Yes	No	No	No	No
Arkansas	No	No	No	No	No
California #	Yes, except G.A.	No	Yes	Yes	No
Colorado	Yes, except G.A.	No	No	No	No
Connecticut #	Yes, except G.A.	No	No	No	No
Delaware	Yes, except APTD and G.A.	No	No	No	No
District of Columbia #	Yes	No	No	No	No
Florida	Yes, except G.A.	No	No	No	No
Georgia	Yes ²	No	No	No	No
Guam	No response				
Hawaii #	Yes	Yes ³	Yes	No	Yes
Idaho	Yes, except G.A.	Yes	No	Yes	No
Illinois #	Yes	No	No	No	No
Indiana	Yes, except G.A.	Yes	No	Yes	Yes
Iowa	Yes, except G.A.	No	No	No	No
Kansas #	Yes	No	No	No	No
Kentucky #	Yes, except G.A.	No	No	No	No
Louisiana	Yes, AFDC only	Yes, AFDC only	No	No	No
Maine	Yes, except G.A.	No	No	No	No
Maryland #	Yes	No	No	No	No
Massachusetts #	Yes	Yes	—	Yes	Yes
Michigan #	Yes, except G.A.	No	No	No	No
Minnesota #	Yes, except G.A.	Yes	Yes	Yes	No
Mississippi	No	No	No	No	No
Missouri	Yes, except G.A.	No	No	No	No, except Model Cities Areas residents
Montana	Yes	No	No	No	No
Nebraska #	Yes	No	No	No	No
Nevada	Yes, except G.A.	No	No	No	No
New Hampshire #	Yes, except G.A.	No	No	No	No
New Jersey	Yes	Yes, AFDC only	Yes, AFDC only	Yes, AFDC only	—
New Mexico	Yes, except G.A.	No	No	No	No
New York #	Yes	No	No	Yes	Yes
North Carolina #	Yes	No	Yes, AFDC only (2 yrs.)	Yes, AFDC only	No
North Dakota #	Yes, local option on G.A.	No	No	No	No
Ohio	Yes	Yes	Yes	Yes	Yes
Oklahoma #	Yes	—	—	—	—
Oregon	Yes	No	No	No	No
Pennsylvania #	Yes	Yes	Yes	Yes	Yes
Puerto Rico #	No ⁴	No	No	No	No
Rhode Island #	Yes	Yes	No	No	No
Samoa	No welfare program				
South Carolina	Yes	No	No	No	No
South Dakota	Yes, except G.A.	No	No	No	No
Tennessee	No	No	No	No	No
Texas	Yes, except G.A.	No ⁴	No ⁴	No ⁴	No ⁴
Utah #	Yes, except G.A.	No	No	No	No
Vermont #	Yes, except G.A.	No	No	No	No

Table 21 (Continued). Groups for Which Welfare Departments Purchase Medical Family Planning Services*

State	Recipients of AFDC, APTD, AB, and GA **	Applicants for Assistance	Past Recipients	Potential Recipients	Residents of Low-Income Areas
Virginia #	Yes, except G.A.	Yes	No	No	No
Virgin Islands #	No ⁵	No	No	No	No
Washington #	Yes	No	No	No	No
West Virginia	Yes	No	No	No	No
Wisconsin #	Yes, except G.A.	No	No	No	No
Wyoming	Yes, except G.A.	No	No	No	No

¹ Only in the absence of a government facility or physician or in unusual circumstances will the Welfare Division pay for family planning services. There is no Medicaid program.

² Private physicians who receive Medicaid payments are the only medical providers that receive reimbursements.

³ "Applicants who are denied financial assistance or medical assistance" are eligible for referral services only.

⁴ Applicants, past recipients, potential recipients and residents of low-income areas may receive medical family planning services if they reside in areas covered by "service projects purchased under assistance title contracts."

⁵ The Medicaid program limits the provision of family planning services to those provided by pharmacies and salaried personnel of publicly operated medical facilities.

⁶ The Medicaid program limits payments for physicians' services to Health Department physicians.

* Definition:

The purchase of medical family planning services by welfare departments includes both purchase of service contracts as authorized by Title IV-A of the Social Security Act and Medicaid reimbursements to medical providers regardless of whether or not the Welfare Department administers the Medicaid program.

** Abbreviations:

• AFDC: Aid to Families with Dependent Children; Title IV-A of the Social Security Act. The needy child must be deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, or if the State so elects, the unemployment of the father (AFDC-UF). Twenty-four states have AFDC-UF programs.

• APTD: Aid to the Permanently and Totally Disabled; Title XIV of the Social Security Act.

• AB: Aid to the Blind; Title X of the Social Security Act.

• GA: General Assistance; state or local welfare assistance to individuals not eligible for assistance under other welfare programs; no Federal financial or administrative participation.

Indicates that the Medicaid program coverage extends to medically needy persons.

A state-by-state comparison of eligibility requirements for adults shows that most health and welfare policies, while not identical for each state, are not in obvious conflict with one another (see Table 22).¹⁶ In five states, however, there does appear to be outright conflict. In Louisiana, Maryland, Missouri, and Rhode Island, the welfare policy is more restrictive than the health policy;¹⁷ in Kansas, where health agency social eligibility requirements are more restrictive than welfare, the welfare agency may be unable to obtain family planning services for all eligible clients from the health agency.¹⁸

Eligibility of Minors

Health Agencies: Forty states and federal jurisdictions have some type of written or unwritten health agency policy on eligibility of minors for family planning services (see Table 22);¹⁹ 16 of these states (Alabama, California, Colorado, Georgia, Illinois, Maryland, Michigan, Mississippi, New Hampshire, Ohio, Oregon, South Carolina, Tennessee, Virginia, Washington and West Virginia) and District of Columbia authorize services for all minors on their own consent (that is, without consent of parent or guardian)²⁰ regardless of age, marital status, parenthood status or pregnancy status.

Twenty-three health agencies impose some type of restriction on the eligibility of minors. These occur as follows:

- Although 21 of these health agencies authorize services to *married minors* without parental consent, two agencies (Kentucky's and Louisiana's) require such consent.

- Twelve health agencies authorize services to *emancipated minors* without parental consent,²¹ but six require such consent;²² Guam limits services to "all parents and would-be parents," and Alaska, Idaho, Kansas and Rhode Island apparently have no provisions relating to emancipated minors.

- Ten health agencies authorize services without parental consent to *minors* with children born out of wedlock;²³ however, 10 require parental consent²⁴ and Kansas, Rhode Island and Utah apparently have no policy provisions relating to such minors.

- Six health agencies authorize services to *previously pregnant minors* without parental consent²⁵ but 13 require parental consent;²⁶ Guam limits services to "all parents and would-be parents," and Kansas, Rhode Island and Utah apparently have no provisions relating to such minors.

- None of these health agencies expressly authorizes services to unmarried, unemancipated, never-pregnant minors *without parental consent*; 20 of them expressly require consent for such minors, and Guam, Kansas and Rhode Island apparently have no provisions relating to such minors.

Welfare Agencies: All welfare agencies of states and federal jurisdictions for which information is available establish some type of policy on eligibility of minors. As noted above, federal regulations under Title IV-A state that family planning services “must be available without regard to marital status, age or parenthood.” While the federal regulations do not expressly address the issue of whether parental *consent* is required it has been construed that a requirement of parental consent is “a form of age restriction.”²⁷ However, the program guidelines to Title IV-A state: “In respect to youths, voluntary consent includes parental consent if such is required by State law.”

Twenty-one state welfare departments (and the District of Columbia) place no policy restrictions on the eligibility of minors for family planning services. The states are: California, Colorado, Delaware, Georgia, Idaho, Illinois, Iowa, Minnesota, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Texas, Vermont, Virginia, Washington, West Virginia and Wyoming.

Thirty-one welfare policies restrict eligibility as follows:

- Twenty-six welfare policies authorize services for *married minors* without parental consent;²⁸ four states, Arkansas, Kansas, Louisiana and South Carolina, require parental consent, and Maryland forbids services to married minors without children.
- Fourteen welfare policies authorize services to *emancipated minors* without parental consent;²⁹ thirteen policies require parental consent,³⁰ and four policies (Connecticut, Maryland, Massachusetts and Wisconsin) forbid services to such minors. (It is not clear in what way many states define “emancipated”; legal or social definitions may vary between states, agencies and individuals queried.)
- Only three welfare policies (Connecticut’s, Florida’s and Maryland’s) authorize services to *minors with one or more out-of-wedlock children* without parental consent; twenty-six policies require parental consent,³¹ and those of Massachusetts and Wisconsin forbid services to such minors.
- Twenty-seven welfare policies require parental consent for unmarried, unemancipated minors, including those who have been pregnant;³² and four policies (Connecticut’s, Maryland’s, Massachusetts’ and Wisconsin’s) forbid services to such minors.

In Massachusetts and Wisconsin, the welfare policy prohibition on services to unmarried minors de-

rives from the state statutes which prohibit prescriptions of contraceptives for all unmarried persons (see Summary and Analysis of Laws, and Massachusetts and Wisconsin State Profiles). On March 22, 1972, the Massachusetts law was held unconstitutional by the U.S. Supreme Court. The welfare policy restrictions in Connecticut and Maryland do not, however, rest on a statutory basis but appear to derive from administrative policy alone. Connecticut permits family planning services without parental consent for married minors and minors with one or more out-of-wedlock children, but forbids services to all other minors, including those who are emancipated and those who have been pregnant, even *with* parental consent. The Maryland welfare agency forbids services to minors unless they have had one or more out-of-wedlock children, despite the fact that neither the state law nor the health agency’s policy restricts services to minors. These two state policies, therefore, appear to be inconsistent with the federal regulations.

Comparison of Health and Welfare Policies on Minors

A state-by-state comparison of health and welfare policies on the eligibility of minors for family planning services reveals a lack of consistency between most policies. In almost one-half of all states and federal jurisdictions there are discrepancies between the health and welfare policies. As shown in Table 23, it was not possible to compare health and welfare policies in 15 states and two jurisdictions. In barely one-quarter of all states and federal jurisdictions are the respective health and welfare policies identical or equivalent.

“Marriage,” “Previous Pregnancy,” “Child(ren),” or “Presence of VD,” as Prerequisites for Eligibility

Some state policies have social eligibility requirements which severely limit access to family planning services to certain types of minors. Among such restrictions are the requirements that individuals be of a stated age, be married, have children, have been pregnant, or give evidence of having venereal disease in order to be eligible for family planning services. Some of these restrictions were intended originally to protect individual interests and to discourage delinquency. Presumably, the intended effect was to insure that the potential patient was “socially qualified” on the basis of current social mores to use contraception (i.e., be married), or that sufficient evidence of previous delinquency was present in order to justify the provision of contraception to avoid further delinquency or medical risk (e.g., the requirements of previous pregnancy, previous births, or presence of VD). Whether these restrictions have had the intended result of discouraging behavior

Table 22.

Social Eligibility Criteria for Family Planning Services in State Health and Welfare Policies

State	All Adults	Categories of Minors Eligible for Services							Sexually Active, Referred by Agency or Physician	Sexually Active, Self-Referred
		All Minors Without Limitation	Married	Emancipated	With Child (ren) Out-of-Wedlock	Previously Pregnant				
Alabama Health Welfare	Yes Yes	Yes No	Yes	Only w/consent*	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	
Alaska Health Welfare	No ¹ No ¹	No No	Yes Yes	— Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	
Arizona Health Welfare	Yes Yes	No No	Yes Yes	Yes Yes	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	
Arkansas Health Welfare	Yes Yes	No No	Yes Only w/consent	Yes Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	
California Health Welfare	Yes Yes	Yes Yes								
Colorado Health Welfare	Yes Yes	Yes Yes								
Connecticut Health Welfare	(Eligibility requirements are locally determined) No ²	No ²	Yes ²	No	Yes ²	No	No	No	No	
Delaware Health Welfare	Yes Yes	No Yes	Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent	
Dist. of Columbia Health Welfare	Yes Yes	Yes Yes								
Florida Health Welfare	Yes Yes	No No	Yes Yes	Yes Only w/consent	Only w/consent Yes	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	
Georgia Health Welfare	Yes Yes	Yes Yes								

Guam Health Welfare	No ³ N/R	No ³	(Eligibility requirements are locally determined)		Only w/consent		Only w/consent		Only w/consent	
Hawaii Health Welfare	Yes Yes	No No	Yes Yes	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent
Idaho Health Welfare	Yes Yes	No Yes	Yes	—	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Illinois Health Welfare	Yes Yes	Yes Yes	Yes Yes	(Eligibility requirements are locally determined)		Only w/consent		Only w/consent		Only w/consent
Indiana Health Welfare	(Eligibility requirements are locally determined)		Yes	No	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Iowa Health Welfare	(Eligibility requirements are locally determined)		Yes	Yes ⁵		Only w/consent		Only w/consent		— Only w/consent
Kansas Health Welfare	No ⁶ Yes	No ⁶ No	— Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Kentucky Health Welfare	Yes Yes	No No	Only w/consent Yes	Only w/consent Yes	Only w/consent Yes	Only w/consent Yes	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent
Louisiana Health ⁷ Welfare	Yes No ⁸	No No	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent
Maine Health Welfare	Yes Yes ⁹	No No	Yes Yes	Yes Yes	Yes Yes	Yes Only w/consent	Yes Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent
Maryland Health Welfare	Yes No ¹⁰	Yes No ¹¹	No ¹¹	No ¹¹	No ¹¹	Yes	No ¹¹	No	No	No
Massachusetts Health Welfare	(Eligibility requirements are locally determined)		No ¹²	Yes	No	No	No	No	No	No
Michigan Health Welfare	Yes Yes ¹⁴	Yes No	Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent

Table 22 (Continued).

Social Eligibility Criteria for Family Planning Services in State Health and Welfare Policies

State	All Adults	Categories of Minors Eligible for Services							Previously Pregnant	Sexually Active, Referred by Agency or Physician	Sexually Active, Self-Referred
		All Minors Without Limitation	Married	Emancipated	With Child (ren) Out-of-Wedlock						
Minnesota Health Welfare	(Eligibility requirements are locally determined) Yes	Yes									
Mississippi Health Welfare	Yes ¹⁵ Yes	Yes ¹⁵ No	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	
Missouri Health Welfare	Yes No ¹⁶	No No	Yes Yes	Yes Yes	Yes Only w/consent	Yes Only w/consent	Yes Only w/consent	Yes Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	
Montana Health # Welfare	Yes Yes	No No	Yes Yes	Yes Yes	Yes Only w/consent	Yes Only w/consent	Yes Only w/consent	Only w/consent ¹⁷ Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent	
Nebraska Health Welfare	(Eligibility requirements are locally determined) Yes	Yes									
Nevada Health Welfare	Yes Yes	No Yes	Yes	Yes	Yes ¹⁸	Only w/consent ¹⁸	Only w/consent	Only w/consent	Only w/consent	Only w/consent	
New Hampshire Health Welfare	Yes Yes	Yes No	Yes	Only w/consent ¹⁹	Only w/consent ¹⁹	Only w/consent ¹⁹	Only w/consent ¹⁹	Only w/consent ¹⁹	Only w/consent ¹⁹	Only w/consent ¹⁹	
New Jersey Health Welfare	(Eligibility requirements are locally determined) Yes	Yes	Yes								
New Mexico Health Welfare	(Eligibility requirements are locally determined) Yes	Yes									
New York Health Welfare	(Eligibility requirements are locally determined) Yes	Yes									
North Carolina Health Welfare	Yes Yes	No Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent	

North Dakota Health Welfare	(Eligibility requirements are locally determined)		Yes	No	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Ohio Health Welfare	Yes ²⁰	Yes	No	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Oklahoma Health Welfare	Yes	No	No	Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent
Oregon Health Welfare	Yes	Yes	No	Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent
Pennsylvania Health Welfare	Yes	Yes	No	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Puerto Rico Health # Welfare	Yes	No	No	Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent
Rhode Island Health # Welfare	Yes	No	No	Yes	—	—	Only w/consent	—	—
Samoa Health Welfare	No ²¹	No	No	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent
South Carolina Health Welfare	N/R	No Program	Yes	No	Only w/consent	Only w/consent	Only w/consent	Only w/consent	Only w/consent
South Dakota Health # Welfare	Yes	No	No	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Tennessee Health Welfare	Yes	Yes	No	Yes	Yes	Yes	Only w/consent	Only w/consent	Only w/consent
Texas Health Welfare	Yes	No	No	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent
Utah Health # Welfare	Yes	No	No	Yes	Yes	Only w/consent	Only w/consent	Only w/consent	Only w/consent

Table 22 (Continued). Social Eligibility Criteria for Family Planning Services in State Health and Welfare Policies

State	All Adults	Categories of Minors Eligible for Services							Sexually Active, Referred by Agency or Physician	Sexually Active, Self-Referred
		All Minors Without Limitation	Married	Emancipated	With Child (ren) Out-of-Wedlock	Previously Pregnant				
Vermont Health Welfare	(Eligibility requirements are locally determined) Yes	Yes								
Virginia Health Welfare	Yes Yes	Yes Yes								
Virgin Islands Health Welfare	Yes Yes	No No	Yes Yes	Yes Yes	Only w/consent Only w/consent	Only w/consent Only w/consent		Only w/consent Only w/consent	Only w/consent Only w/consent	Only w/consent Only w/consent
Washington Health # Welfare	Yes Yes	Yes Yes								
West Virginia Health Welfare	Yes Yes	Yes Yes								
Wisconsin Health Welfare	(Eligibility requirements are locally determined) No 22	No	Yes	No	No	No		No	No	No
Wyoming Health Welfare	(Eligibility requirements are locally determined) Yes	Yes								

Table 22.

Definitions:

* "Consent," in the legal sense, means the permission or authorization of a parent, guardian or other individual or agency legally authorized to act *in loco parentis* to permit the giving of medical family planning services to a minor.

The social eligibility requirements indicated here were reported by the health agency in the 1971 CFPPD survey; however, the health agency did not indicate whether these requirements were established by or recommended in official health agency policies, nor were these requirements stated in available written policies. While some health agencies do not have official eligibility policies, they nevertheless recognize and abide by policies and laws otherwise established. These may represent "unofficial" or "unwritten" policies of the health agency or interpretations of relevant statutes.

¹ "Information shall be provided upon written request to any person. It shall be provided upon verbal request to any married person or mother, to any person referred for such by a physician, or as a part of premarital counseling. (Policy Statement on Family Planning, Division of Public Health, July 5, 1966 and according to the Division of Social Service Staff Manual, Subsection 3511.)

² Only adult or minor AFDC recipients who are "the head of a family" are eligible to receive family planning services.

³ Medical family planning services are available to "all parents and would be parents" according to the health agency.

⁴ "In those few instances where contraceptive medicines or devices are purchased directly by the Iowa State Department of Health and provided for use in family planning clinics, they are not dispensed to unmarried minors without written parental or guardian consent," according to a letter from the Chief, General Health Services, to the Region VI Program Management Officer, NCFPS, DHEW, November 20, 1970.

⁵ Parental consent is not required for the provision of services to minors; but, except for married minors and minors with out-of-wedlock child or children, parental consent is desirable.

⁶ Clinic services are available to persons who are over 18 years of age and who are married or who are referred by a physician. In the case of an unmarried adult, "this has been broadly interpreted by most clinics so that the clinic physician himself may make a referral," according to a letter from the Director of the Department's Division of Maternal and Child Health to the Region VII Program Management Officer, National Center for Family Planning Services, DHEW, dated November 4, 1970. With respect to minors, local health departments' practices vary: "A number attempt to obtain parental consent for those under 18, however, most do see persons who are at risk of becoming pregnant, regardless of age," according to the MCH unit.

⁷ Information on state health agency family planning policy contained in this section was taken from a letter from the State Health Officer to the Region IV Program Director, The National Center for Family Planning Services, DHEW, dated November 12, 1970; and subsequently verified by the State Health Officer in September, 1971. A survey questionnaire was not completed.

⁸ Married or unmarried adults without children are not eligible for services.

⁹ There is a conflict in the written policies but the most recent policy indicates that family planning "services will be available without regard to marital status, age, or parenthood."

¹⁰ Married or unmarried adults without children are not eligible for services.

¹¹ Married or unmarried minors without children are not eligible for services.

¹² Unmarried adults may not be referred for contraceptive services.

¹³ Unmarried minors may not be referred for contraceptive services.

¹⁴ "Written permission of the client or spouse to provide family planning services is required." Paragraph C, Section C—Manual of State Department of Social Services.

¹⁵ Information on Mississippi health agency policy is from the 1970 NCFPS letter of inquiry. The information has not been verified more recently; the policy material is undated.

¹⁶ The policy authorized the provision of family planning information "to parents of children receiving ADC, and other forms of assistance payments." Thus, the formal policy authorizes services only for adults and minors who are parents.

¹⁷ Sexually active minors are eligible for family planning services "only if they profess to have venereal disease or are pregnant." In those cases parental consent is not required.

¹⁸ Minors who "have had a baby" are eligible without consent.

¹⁹ Unmarried minors under the age of 18 must have parental consent but unmarried minors over the age of 18 are eligible for services without parental consent.

²⁰ These standards are from the state health agency's guidelines for application for MCH funds from local agencies. Eligibility standards are otherwise locally determined.

²¹ An unmarried adult without a child or children is not eligible.

²² Wisconsin law limits the provision of family planning services to married persons.

Table 23.**Comparison of Health and Welfare Eligibility Policies on Minors**

Essentially Identical Policies	Health More Restrictive Than Welfare*	Welfare More Restrictive Than Health	Policies Not Comparable**
Alaska# Arizona California Colorado District of Columbia Georgia Hawaii Illinois Utah Virginia Virgin Islands Washington# West Virginia	Delaware# Idaho Kansas Kentucky Nevada# North Carolina South Dakota Texas	Alabama Arkansas Louisiana Maine# Maryland Michigan Mississippi Missouri# Montana New Hampshire# Ohio Oklahoma Oregon Puerto Rico Rhode Island South Carolina Tennessee	Connecticut Florida# Guam# Indiana Iowa Massachusetts Minnesota Nebraska New Jersey New Mexico# New York North Dakota Pennsylvania Samoa Vermont Wisconsin# Wyoming#
13 (2#)	8 (2#)	17 (3#)	17 (5#)

* A more "restrictive" policy in this context means a policy which places greater limitations or qualifications on the eligibility of a given category of individuals for family planning services. For example, a policy which requires a minor to have one or more children, or to have parental consent, etc., in order to be eligible is more restrictive than one which does not.

** In 15 states and two federal jurisdictions, it was not possible to compare health and welfare policies:

In 14 states, health departments leave eligibility determinations to local jurisdictions.

In Guam and Samoa, health policy information was not available (Samoa has no welfare program.)

In Florida the health and welfare policies are identical except with respect to emancipated minors and minors with one or more children out-of-wedlock. The welfare policy requires parental consent for the first group; the health policy requires parental consent for the second group; therefore, a judgment on the relative restrictiveness of the policies is not feasible.

Eleven states and Guam have combined health and welfare departments.

regarded as undesirable is questionable. There is no evidence that restrictions on accessibility to contraception, for instance, inhibit minors from sexual activity. That it exposes such minors to the manifold risks of unexpected or unwanted pregnancy, including maternal morbidity and mortality, illegal abortion, and economic dependency, is apparent to workers and researchers in the family planning field. The trend toward removal of such restrictions by state legislatures, health departments, and welfare agencies, as observed in the NCFPS and CFPPD surveys, is evidence that these insights are shared increasingly by state officials.

Geographical Eligibility Requirements

State health policies seldom include eligibility requirements for family planning services based on the potential patient's residence or state citizenship. Only seven state health agencies (Colorado, Florida, Mississippi, Oregon, Tennessee, Texas and Utah), establish such geographical eligibility requirements for family planning. Among these, the most common requirement is that persons otherwise eligible for family planning services must be residents of the

state or county in order to be eligible for services *provided by the health department*. Five state health agencies (California, Maryland, New Hampshire, Rhode Island and West Virginia), either recommend against or prohibit geographical eligibility requirements in state or local health agency programs (see Table 19, above).

Despite the absence of specific geographical eligibility requirements in most state health policies, limitations on eligibility based on local residence may be more common in county or other local health policies. Such local policies were not investigated in this study.

Geographic criteria for eligibility are even less evident in welfare policies than in health policies. But the basic administrative unit of state welfare programs is the county welfare agency which makes eligibility determinations and carries out counseling and referral activities. As in the case of health agencies, local welfare agencies may impose geographical eligibility restrictions not found in state policies. Local welfare policies were not investigated in this study.

As mentioned earlier, welfare departments *must*

provide for family planning services to their basic caseload, i.e., current recipients of cash assistance. They *may* also extend eligibility coverage to include applicants, past recipients and potential recipients of assistance and "residents of low-income areas." In the latter case, residence in a particular location (e.g., a Model Cities area) may enable an individual to qualify for family planning services under a welfare program. Only six states reported in the CFPPD survey that residents of low-income areas are eligible for family planning medical services. These are: Hawaii, Indiana, Massachusetts, New York, Ohio, and Pennsylvania. Missouri indicated that the only residents of low-income areas eligible for services are those in Model Cities areas. Texas reported that only low-income area residents covered by the Department's Title IV-A contracts are eligible for services. The 43 other states and federal jurisdictions indicated that they do not cover residents of low-income areas. No information was available for New Jersey, Oklahoma, and Guam regarding this provision. Samoa has no welfare program.

Financing of Family Planning Services

The primary federal authority and funding source for the financing of family planning services by state health agencies is Title V of the Social Security Act. Title V authorizes the Secretary of HEW to allocate to the states MCH formula grants which may, in addition to other services for mothers and children, be utilized for family planning services. The funds are allocated on the basis of a formula which takes into account urban and rural population and various indices of maternal and child health. Title V also authorizes a family planning project grant program and the Maternity and Infant Care (MIC) projects which also may be used to finance family planning services. Other funding available to state health agencies for family planning services is authorized by Title X of the Public Health Service Act. (See Summary and Analysis of Federal Laws and Policies, and individual federal profiles for fuller discussion of these federal programs.)

The utilization of MCH formula grant funds for family planning services varies from state to state. Partly due to the tradition that public health programs supplement personal health services locally available in the private sector, the application of MCH formula grant funds to family planning program needs has been determined largely on a state-by-state basis, and in light of local perceptions about the availability of services from such sources as hospitals, private doctors and Planned Parenthood clinics. Furthermore, since the nature of the formula grant process does not lend itself to a high degree of supervision and program direction at either the federal or state level, the tendency towards localized control is increased with respect to such issues as

program design and the determination of eligibility standards.

In FY 1971, a portion of the total allocation of MCH formula grant funds was for the first time earmarked for family planning services. The Director of DHEW's Maternal and Child Health Service announced in May 1970 that state health agencies would be required to allocate 90 percent of their FY 1971 *increases* in MCH formula grant funds to family planning services.³³ This special allocation was repeated in FY 1972 and is projected again in the President's budget for FY 1973. In FY 1971, the final allocation among states of these earmarked funds was \$8,250,000.³⁴

Authority for the financing of family planning services by state welfare agencies is contained in Titles IV-A and XIX of the Social Security Act. Title IV-A requires state welfare agencies to secure family planning services on behalf of "appropriate" recipients of AFDC. Title IV-A administrative regulations state that welfare agencies must "offer and provide" medical, social and educational family planning services. These regulations further provide that when free public or private family planning services are inadequate to meet the family planning service needs of welfare recipients, the welfare agency is authorized to provide these services through purchase of service arrangements. Federal matching funds are available at a rate of three federal dollars for each state dollar expended for these services. (See Federal Laws and Policies Section, Profile on Title IV-A.)

The Medicaid program established by Title XIX is the authority for welfare agencies to purchase general medical care for recipients of cash assistance. All current welfare recipients are eligible for a stated range of medical benefits, some of which are required by federal law, while others may be provided at the states' option. Medical providers approved by the state receive reimbursement for the approved services they provide to Medicaid eligibles.

Financing: Health Agencies

In FY 1971 health agencies of 54 states and federal jurisdictions were allocated \$8,250,000 of increased MCH formula grant funds which were specifically earmarked for family planning services (see Table 24).³⁵ In response to the CFPPD survey, health agencies indicated that a total of \$5,789,928, or 70 percent, of these funds were spent for family planning services by 41 states and the District of Columbia.

- Twenty-four states and the District of Columbia indicated that they spent all of the earmarked funds allocated to them. (Alaska, Arizona, Connecticut, Georgia, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New York, North Dakota,

Table 24. Financing of Family Planning Services through State Health Agencies:
Maternal and Child Health (MCH) Formula Grants; State Legislative Appropriations; Other State Funds, FY 1971

State or Jurisdiction	MCH Formula Grant Funds†					Legislative Appropriations for Family Planning	Other Health Agency Funds Spent on Family Planning
	Earmarked for Family Planning			Nonearmarked Funds			
	Allocated‡	Obligated Amount	Per- cent‡	Allocated§	Estimated Spent on Family Planning**		
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Alabama	\$ 212,556	\$ 202,203	95.0	\$ 1,077,593	\$ 91,000	\$ 0	\$ 0
Alaska	8,615	8,615	100.0	177,000	1,985	24,600	0
Arizona	70,444	70,444	100.0	363,990	27,300	0	0
Arkansas	117,345	na	na	577,258	294,493	0	0
California	488,349	356,745	73.0	2,339,805	324,214	(1,000,000)*	0
Colorado	92,348	40,000	43.3	376,900	0	46,667	0
Connecticut	54,511	54,511	100.0	440,210	86,251	0	0
Delaware	10,737	na	na	200,459	8,500	100,024	0
D. C.	12,737	12,737	100.0	247,944	na	na	663,902
Florida	299,169	0	0.0	1,359,924	168,794	200,000	0
Georgia	316,201	316,201	100.0	1,319,584	501,608	(250,000)*	167,000
Guam	5,481	na	na	152,683	na	na	na
Hawaii	16,103	16,103	100.0	228,997	12,147	0	33,007
Idaho	17,825	17,825	100.0	217,045	16,175	0	30,000
Illinois	271,296	271,296	100.0	1,353,163	71,704	0	0
Indiana	222,464	107,000	48.0	1,035,547	37,000	0	0
Iowa	114,358	114,358	100.0	576,764	129,106	0	0
Kansas	87,789	63,395	72.2	391,981	60,000	70,000	15,000
Kentucky	217,087	217,087	100.0	931,998	32,693	29,000	31,762
Louisiana	236,572	na	na	1,099,765	na	0	na
Maine	43,589	40,000	91.8	286,487	60,000	0	0
Maryland	255,368	255,368	100.0	808,362	na	0	0
Massachusetts	128,180	128,180	100.0	718,881	0	0	28,100
Michigan	338,843	254,000	75.0	1,545,513	na	(100,000)*	0
Minnesota	157,993	157,993	100.0	752,110	123,662	0	0
Mississippi	174,528	na	na	878,071	na	na	na
Missouri	208,733	195,000	93.4	865,304	0	0	0
Montana	14,070	14,070	100.0	212,615	25,192	0	na
Nebraska	57,018	41,494	72.7	289,361	na	0	0
Nevada	11,127	11,127	100.0	191,580	56,500	0	4,627
New Hampshire	14,417	14,417	100.0	215,464	583	(10,000)*	0
New Jersey	186,858	180,961	96.8	874,629	119,039	100,000	73,392
New Mexico	43,483	na	na	281,543	68,000	0	0
New York	452,236	452,236	100.0	2,199,704	120,000	(500,000)*	103,000
North Carolina	341,461	69,568	20.3	1,545,741	75,484	0	0
North Dakota	11,431	11,431	100.0	205,130	15,844	0	0
Ohio	393,156	383,000	97.2	1,867,731	407,000	0	na
Oklahoma	112,783	112,783	100.0	494,057	32,114	200,000	0
Oregon	100,047	100,047	100.0	434,508	282,430	29,880	0
Pennsylvania	419,405	328,777	78.3	2,092,697	21,000	0	0
Puerto Rico	255,992	na	na	1,390,237	na	496,280	0
Rhode Island	15,461	10,000	64.7	234,970	35,245	56,000	0
Samoa	no program					na	na
South Carolina	195,728	185,940	90.0	931,904	196,282	0	0
South Dakota	14,715	0	0.0	208,877	30,000	0	0
Tennessee	215,866	na	na	998,326	na	400,000	0
Texas	476,029	469,970	98.7	2,108,291	127,000	0	325,936
Utah	70,838	70,838	100.0	334,024	17,162	0	0
Vermont	9,030	9,030	100.0	186,301	44,320	0	0
Virginia	224,501	164,703	73.3	1,101,080	141,447	0	0
Virgin Islands	3,267	na	na	153,735	na	(116,412)*	16,860
Washington	171,385	na	na	623,001	na	0	0
West Virginia	108,366	108,366	100.0	515,684	40,065	0	174,000
Wisconsin	144,294	144,294	100.0	852,805	64,575	0	0
Wyoming	7,815	7,815	100.0	173,908	0	0	0
Total	\$8,250,000	\$5,789,928	70.2	\$40,987,500	\$3,965,914	\$1,752,451 (3,728,863)*	\$1,666,586

Table 24 (Continued).

**Financing of Family Planning Services through State Health Agencies:
Maternal and Child Health (MCH) Formula Grants; State Legislative Appropriations; Other State Funds, FY 1971**

Number Jurisdictions	Reporting MCH Formula Grant Funds		Reporting Legislative Appropriations for Family Planning	Reporting Other Health Agency Funds Spent on Family Planning
	Earmarked for Family Planning	Nonearmarked Funds		
Reporting Expenditures	42	39	19	11
Reporting no Expenditures	2	4	33	37
Information not available	10	11	3	7
No MCH Prog.	1	1		
	55	55	55	55

* FY 1972 appropriations are listed for six states which responded with these figures instead of FY 1971 appropriations in the 1971 CFPPD survey.

† The estimated awards for FY 1971 and the allocation of MCH funds earmarked for family planning are presented here as reported in Director's Letter, MCH-71-1, January 22, 1971.

‡ The proportion of earmarked MCH funds obligated is based on data on amounts obligated as reported by state health agencies in the 1971 CFPPD survey.

§ The FY 1971 allocation of nonearmarked MCH funds for FY 1971 represents the total MCH allocation by state minus the funds earmarked for family planning (Col. 2) and funds for special projects.

** The estimated amount of nonearmarked MCH funds spent for family planning services is derived from data provided by state health agencies.

Oklahoma, Oregon, Utah, Vermont, West Virginia, Wisconsin and Wyoming).

- Seven states spent nearly the total amount of their earmarked allocations. (Alabama, Maine, Missouri, New Jersey, Ohio, South Carolina and Texas).

- Michigan and Pennsylvania spent between 75 and 89.9 percent of their allocations.

- Eight states spent less than 75 percent of their allocations (California, Colorado, Indiana, Kansas, North Carolina, Nebraska, Rhode Island and Virginia).

- Two states reported no expenditure of these funds (Florida and South Dakota); Florida indicated in the CFPPD survey that it received these funds too late in the year to obligate them.

- No information on these expenditures was available from 10 states and jurisdictions (Arkansas, Delaware, Guam, Louisiana, Mississippi, New Mexico, Puerto Rico, Tennessee, Virgin Islands and Washington) and Samoa has no MCH program.

The overall pattern of expenditures was as follows:

Number of States and Federal Jurisdictions Spending Earmarked MCH Funds in FY 1971, by Percent of Allocation Expended	
State or Federal Jurisdiction	Percent of Allocation Expended
25	100 percent
7	90-99.9 percent
2	75-89.9 percent
5	50-74.9 percent
2	25-49.9 percent
1	0-24.9 percent
2	0
10	Information Unavailable
1	No Program
55	Total

In addition to the earmarked MCH funds expended in FY 1971, health agencies reported spending varying amounts of their regular, nonearmarked MCH formula grant allocations for family planning services in FY 1971. The total allocation of these nonearmarked MCH funds was \$40,987,500.³⁶ Of the 39 states and federal jurisdictions which reported spending some of these nonearmarked MCH formula grant funds for family planning services in FY 1971:

- Three states estimated that they spent more than \$300,000 each (California, Georgia and Ohio).
- Ten states reported spending \$100,000–300,000 (Arkansas, Florida, Iowa, Minnesota, New Jersey, New York, Oregon, South Carolina, Texas and Virginia).
- Twenty-six states reported spending up to \$100,000 (Alabama, Alaska, Arizona, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, West Virginia, Wisconsin); of these, 14 states reported spending from \$25,000–100,000, and the rest spent less than \$25,000 (see Table 24).
- Four states reported that they made no expenditures from these funds for family planning services (Colorado, Massachusetts, Missouri and Wyoming).
- No information was reported for 11 other states and federal jurisdictions (District of Columbia, Guam, Louisiana, Maryland, Michigan, Mississippi, Nebraska, Puerto Rico, Tennessee, Virgin Islands, and Washington) and Samoa had no MCH program.

In aggregate, a total of twenty-three states and federal jurisdictions spent less than \$25,000 of their regular MCH formula grant apportionments for family planning services in FY 1971, or were unable to estimate such expenditures. Since the nonearmarked apportionment represents the previous year's funding level, and since FY 1971 was the first year in which apportionments of MCH formula grant funds were earmarked for family planning, these expenditure data are suggestive of the varying levels of priority accorded to family planning services by different state health agencies prior to the earmarking policy.

The level of priority assigned by health agencies to family planning services is also indicated by the extent of legislative appropriations, if any, to health agencies specifically for family planning services. A total of eighteen health agencies of states and federal jurisdictions reported legislative appropriations totaling \$3,728,863 for family planning services in the CFPPD survey. California reported a \$1 million ap-

propriation for FY 1972. These funds will serve as local matching for a Title IV–A family planning services program in California. Six health agencies (Florida's, Georgia's, New York's, Oklahoma's, Puerto Rico's and Tennessee's) reported appropriations of \$200,000–500,000 in FY 1971 or FY 1972. Health agencies in Delaware, Michigan, New Jersey and the Virgin Islands reported appropriations of \$100,000–200,000 in FY 1971 or FY 1972. Seven states (Alaska, Colorado, Kansas, Kentucky, New Hampshire, Oregon and Rhode Island) reported appropriations of less than \$100,000. Thirty-three health agencies reported no family planning appropriations in this period (see Table 24). No information was available for Mississippi, the District of Columbia, Guam or Samoa.

In addition to expenditures of MCH formula grants and state legislative appropriations, some health agencies committed additional funds for family planning services in FY 1971. Ten states, the District of Columbia and the Virgin Islands indicated in the CFPPD survey that they made additional expenditures of local funds totaling \$1,666,586. Most of these individual expenditures were small and were made for such purposes as the provision of matching funds for federal family planning project grants or purchase of supplies. Of these 12 agencies, seven (Hawaii's, Idaho's, Kansas', Kentucky's, Massachusetts', Nevada's, and the Virgin Islands') reported expenditures of less than \$100,000; three (Georgia's, New York's and West Virginia's) indicated expenditures of \$100,000–200,000; Texas indicated expenditures of approximately \$326,000 for the purpose of matching federal projects grants in four locations; and the District of Columbia reported expenditures of \$663,902.

Financing: Welfare Agencies

As indicated above, the main authority utilized by welfare agencies to purchase family planning services for welfare recipients is the Medicaid program established by Title XIX of the Social Security Act. The CUNY study reported that projected expenditures for family planning clinical services in FY 1970 were \$272,959 under Medicaid as opposed to \$26,312 under Title IV–A. In the same period, projected expenditures for contraceptive drugs and devices were \$2,244,627 under Medicaid, whereas no estimates were available for similar purchases under Title IV–A. Four states (Illinois, Oregon, Pennsylvania and South Dakota) purchased both family planning clinical services and drugs and devices under Medicaid; five states (California, Iowa, Kansas, Missouri and Ohio) purchased drugs and devices only under Medicaid; and only two states (Arizona and Florida) purchased family planning clinical services under Title IV–A as well as under Medicaid. The

Table 25.

Welfare Family Planning Referral Policy, by State*

States Which Require Local Agencies to Refer Recipients for Family Planning Services	States Which Recommend that Local Agencies Refer Recipients for Family Planning Services	States Which Authorize Local Agencies to Refer Recipients for Family Planning Services	States Which Leave to Local Option the Referral of Recipients for Family Planning Services
<ol style="list-style-type: none"> 1. Alaska 2. Arizona 3. Arkansas 4. California 5. Colorado 6. Georgia 7. Hawaii 8. Idaho 9. Illinois 10. Indiana 11. Iowa 12. Louisiana 13. Maryland 14. Minnesota 15. Missouri 16. Montana 17. Nebraska 18. Nevada 19. New Jersey 20. New Mexico 21. New York 22. North Carolina 23. North Dakota 24. Ohio 25. Pennsylvania 26. Tennessee 27. Texas 28. Vermont 29. Virgin Islands 30. Virginia 31. Washington 32. West Virginia 	<ol style="list-style-type: none"> 1. Alabama 2. Florida 3. Kentucky 4. Mississippi 5. Oklahoma 6. Puerto Rico 7. South Carolina 8. South Dakota 9. Utah 10. Wyoming 	<ol style="list-style-type: none"> 1. Connecticut 2. Delaware 3. District of Columbia 4. Kansas 5. Massachusetts 6. Michigan 7. New Hampshire 8. Oregon 9. Rhode Island 10. Wisconsin 	<ol style="list-style-type: none"> 1. Maine

* No information is available on the welfare program in Guam; Samoa has no welfare program.

CUNY study reported that other states may have made family planning expenditures, but were unable or unwilling to identify them.³⁷

Furthermore, it is apparent from both the CFPPD survey and the CUNY study that many state welfare agencies have interpreted the Title IV-A mandate concerning the provision of family planning services as a requirement to *refer* welfare recipients to existing family planning services rather than as a requirement to *purchase these services*. For example, although 42 states and federal jurisdictions require or recommend that local welfare agencies refer welfare recipients to family planning sources, only 28 states require or even recommend the purchasing of family planning services where local free services are not available (see Tables 25 and 26). Moreover, Alabama, Alaska, Arkansas, Mississippi, Puerto Rico, Tennessee and the Virgin Islands which either re-

quire or recommend referral for family planning services, do not authorize the purchase of these services. The majority of those states which do require or recommend the *purchase* of services utilize the purchasing mechanism provided under the state's Medicaid program, rather than those authorized under Title IV-A. In doing so, most welfare agencies not only do not take advantage of the better matching features of Title IV-A (only six states receive a higher federal matching rate for family planning services under Medicaid than under Title IV-A), but also lose the advantages of more direct management control afforded by the contract purchase provisions of Title IV-A.

Thus, in the provision of family planning services, as with the entire range of supportive social services, welfare agencies have followed the traditional pattern of relying on existing community service

Table 26. Policies Regarding Purchase of Family Planning Services by Local Welfare Agencies

Required*	Recommended*	Authorized*	Through Medicaid	Not Authorized
1. Arizona 2. California 3. Colorado 4. Georgia 5. Hawaii 6. Idaho 7. Illinois 8. Iowa 9. Louisiana † 10. Minnesota 11. Montana 12. Nebraska 13. Nevada 14. New York 15. North Carolina 16. North Dakota 17. Ohio 18. Oregon 19. Pennsylvania 20. Washington 21. West Virginia	1. Florida 2. Kentucky 3. Missouri 4. Oklahoma 5. South Carolina 6. South Dakota 7. Wyoming	1. Connecticut 2. Delaware 3. Indiana 4. Kansas 5. Maryland 6. Massachusetts 7. Michigan 8. New Hampshire 9. Rhode Island 10. Texas 11. Wisconsin	1. D.C. 2. Maine 3. New Jersey 4. New Mexico 5. Utah 6. Vermont 7. Virginia	1. Alabama 2. Alaska ‡ 3. Arkansas 4. Mississippi 5. Puerto Rico 6. Tennessee 7. Virgin Islands

* Most states in Columns 1-3 purchase service through their Medicaid programs as well as express policies to require, recommend or authorize local agencies to purchase services.

† State Department of Public Welfare purchases statewide family planning services from a nonprofit corporation which serves as a referral source for local welfare agencies.

‡ Only in the absence of a government facility or physician or in unusual circumstances will the Welfare Division pay for family planning services. There is no Medicaid program.

sources. The Medicaid purchase mechanism is compatible with this approach.

In a number of states, however, it has been possible to distinguish more deliberate alternative approaches to the purchase of family planning services. Four states and two federal jurisdictions, for example, made specific legislative appropriations to welfare agencies for family planning services in FY 1971: Arizona, \$35,000; Louisiana, \$250,000; North Carolina, \$93,750; Puerto Rico, \$500,000; South Dakota, \$40,000; the Virgin Islands, \$13,000.

In addition, the California FY 1972 legislative appropriation to the health department, mentioned above, is to be used as local matching for a Title IV-A program in that state. These appropriations are an indication that the welfare agency may be undertaking the purchase of family planning services on a more direct, perhaps contractual, basis, utilizing the Title IV-A authority and federal matching provisions. The current 75 percent federal-25 percent state and local matching provisions under Title IV-A would enable the states essentially to quadruple the amounts of their appropriations.

Six states (Arizona, Louisiana, North Carolina,

Pennsylvania, Texas and Michigan) have utilized the Title IV-A provisions to some extent. The Louisiana welfare agency utilizes its legislative appropriations as a match for federal funds to purchase family planning services on a statewide basis from Family Health, Inc., a private, nonprofit corporation. The North Carolina welfare agency purchases family planning services through its county agencies from county health departments, utilizing its legislative appropriation in conjunction with local welfare agency matching funds. An interagency agreement has been developed between the North Carolina state health and welfare agencies regarding eligibility standards, purchasing arrangements, and county plan requirements. Under the agreement, county health and welfare agencies are required to develop local interagency agreements. The Pennsylvania welfare agency has contracted through the county commissioners in one county for the purchase of family planning services under the Title IV-A authority. The Texas Department of Public Welfare has also entered into purchase of service arrangements under the Title IV-A authority in three areas of the state, employing various matching approaches.

Administration: Health

Administrative responsibility for health agency family planning programs is located in Maternal and Child Health (MCH) units in 36 states and Puerto Rico.³⁸ Four of these states (Maryland, Massachusetts, New York and Tennessee) have specifically designated family planning subunits within their MCH units (Table 27). In eight other states (Alaska, Hawaii, Illinois, Maine, Montana, Rhode Island, South Dakota and Washington) and the District of Columbia health agency family planning program responsibility is assigned to such units as Child Health, Children's Health, Family Health and Community Health. Health agencies in Virginia and New Jersey have separate identifiable family planning units. Only four agencies (Utah's, Vermont's, Wyoming's and the Virgin Islands') do not assign family planning to a particular administrative unit. No information is available on the administrative structure of health agencies in Louisiana, Guam and Samoa.

Table 27 shows that health agencies in 16 states do not assign any staff to full-time family planning activities.³⁹ But at least one staff professional is assigned full-time to family planning activities in the health agencies of 32 states,⁴⁰ the District of Columbia, Puerto Rico and the Virgin Islands. A total of 130 health personnel are assigned to a variety of full-time family planning activities in these states and federal jurisdictions of which 38 are assigned locally to field or to clinic activities.^{40a} No information is available on family planning staffs in the health agencies of Louisiana, Mississippi, Guam and Samoa. Additional health agency personnel spend less than full-time on family planning activities. When part-time staff assignments are included, all state and federal jurisdictions have some health agency personnel assigned to family planning.⁴¹ Among all health agencies, there were 66 staff members who spent from 25 to 50 percent of their time on family planning, 97 who spent from 10 to 25 percent, and 116 who spent less than 10 percent of their time.

In all, state health agencies reported a total of 409 family planning staff: 130, full time; 66, one-quarter to one-half time; and 213 who spend less than one-quarter of their time on family planning.

Although there is a variation among the different agencies, the typical state health agency performs the following family planning functions: consultation, training, development and distribution of public educational materials, the purchase or provision of supplies, equipment or other materials, and the provision of grants or contracts to local family planning programs for support of services.

Administration: Welfare

In state welfare agencies administrative responsibility for family planning programs tends to rest with the bureau, division, section or unit which administers welfare social services programs for families and children (Table 28). However, four states (Arkansas, Kansas, Missouri and Vermont) and Puerto Rico do not assign family planning program responsibility to any particular division, subunit or section in the welfare agency. Georgia is the only welfare agency that has a designated family planning unit.

Welfare agencies in six states (California, Georgia, Iowa, Minnesota, North Carolina and Tennessee) and three jurisdictions (District of Columbia, Puerto Rico and the Virgin Islands) have one or more staff members assigned full-time to family planning. New York and Virginia each have one staff member who devotes at least 75 percent of his or her time to family planning activities. Excluding New York and Virginia, there are a total of 16 professional staff members assigned full-time to family planning activities in welfare agencies of the above six states and three jurisdictions. Twenty-two states, however, assign no welfare personnel to family planning activities on either a full- or part-time basis.⁴² No information is available on welfare staff assignments in Guam; Samoa has no welfare program. Two states (Massachusetts and Washington) each have one welfare staff member who devotes from 25 to 50 percent of his time to family planning. Among all the states from which information is available there are 15 staff members who spend from 10 to 25 percent of their time on family planning and 39 who spend less than 10 percent of their time. In addition to part-time assignments in the state welfare office, New York and North Carolina have a total of thirty-one personnel who spend 10-25 percent of their time on family planning in what appear to be field positions.

In all, state welfare agencies reported a total of 74 family planning staff: 16, full-time; two, almost full-time; two, one-quarter to one half time; and 54 who spend less than one-quarter of their time on family planning.

Family planning program activities of state welfare agencies are mainly confined to the training of local welfare staffs and the development and distribution of public educational material.

VOLUNTARY STERILIZATION POLICIES

Only 16 health agencies of states and federal jurisdictions have a written policy on voluntary sterilization⁴³ (Table 29). Thirty-five health agencies do not have written policies, and no information was available for four. However, in many cases where health agencies do not have a written policy as such,

Table 27.

Administration of State Health Agency Family Planning Programs

X = Headquarters staff ① = Field staff

State	Agency Responsible for Family Planning	Number and Title of Professional Staff	Time Devoted to Family Planning			
			Less than 10%	10% to 25%	25% to 50%	Full Time
Alabama	Bureau of Maternal and Child Health	1 Medical Doctor 1 Registered Nurse 1 Registered Nurse		X X		X
Alaska	Child Health Section	Chief of Child Health Nurse/Supervisor 1 Nurse/Supervisor		X		X
Arizona	Maternal and Child Health Division	1 Medical Doctor 1 Public Health Nurse 1 School Nurse/Consultant			X X	
Arkansas	Maternal and Child Health Division	3 Physicians 2 Nurses 1 Nutritionist 1 Social Worker			X	X X X
California	Bureau of Maternal and Child Health	Bureau Chief 1 Physician 1 Maternal Nursing Consultant 1 Maternal Nursing Consultant 10 "Other Professionals"	X			X X X
Colorado	Maternal and Child Health Section, Child Health Services Division	Division Director 1 Public Health Educator 1 Nutrition Consultant Social Work Section Chief 1 Public Health Coordinator 1 School Nursing Consultant 1 Program Consultant 1 Administrative Assistant		X X X	X X	
Connecticut	Maternal and Child Health Section, Community Health Division	1 Public Health Program Coordinator 1 Social Work Consultant 2 Public Health Nursing Consultants Community Health Division Director MCH Section Chief	X X		X X	75%
Delaware	Office of Maternal and Child Health Services, Division of Physical Health	1 Public Health Nurse 1 Public Health Nurse 2 Registered Nurses 1 Licensed Practical Nurse	X	X X X		X

Table 27 (Continued).

Administration of State Health Agency Family Planning Programs

X = Headquarters staff ① = Field staff

State	Agency Responsible for Family Planning	Number and Title of Professional Staff	Time Devoted to Family Planning			
			Less than 10%	10% to 25%	25% to 50%	Full Time
Kansas*	Division of Maternal and Child Health	MCH Director 1 Family Planning Project Director 7 Project Nurses (assigned to rural areas) 1 Social Worker 1 Nurse Educator 1 Consultant-School Health Nurse 2 Consultant MCH Nurses 1 Health Educator 5 Program Workers (assigned to rural project)			X	X ①
Kentucky	Division of Maternal and Child Health	1 Family Planning Program Director 2 Nursing Consultants 1 Statistician			X	X X
Louisiana	No information					
Maine	Division of Child Health	1 Program Director 1 Division Director		X		X
Maryland	Maternity and Family Planning Section, Division of Maternal and Child Health, Bureau of Preventive Medicine	1 Program Director (Physician) 3 Consultant Physicians 1 Consultant Physician 2 Nursing Consultants 1 Social Worker 1 Administrator				65% X
Massachusetts*	Family Planning Program, Bureau of Adult and Maternal Health Services, Division of Family Health Services	1 Division Director 1 Bureau Director 1 Project Director 1 Training Director 2 Area Specialists 3 Social Service Technicians 1 Obstetrician-Gynecologist Consultant 1 Nursing Consultant 12 Regional Registered Nurses	X	X	X X	X X X X
						X ①

Table 27 (Continued).

Administration of State Health Agency Family Planning Programs

X = Headquarters staff ① = Field staff

State	Agency Responsible for Family Planning	Number and Title of Professional Staff	Time Devoted to Family Planning			
			Less than 10%	10% to 25%	25% to 50%	Full Time
New York	Bureau of Maternal and Child Health and Family Planning	2 Public Health Physicians 1 Physician 1 Public Health Educator 1 Public Health Nurse			X X	X X
North Carolina	Maternal Health Section, Personal Health Division	Personal Health Division Director Maternal Health Section Chief 1 Family Planning Consultant 1 Social Work Coordinator 1 Health Administrator 1 Public Health Nurse		X X X X	X	X
North Dakota	Division of Maternal and Child Health	1 Nursing Consultant 1 Social Services Consultant				X X
Ohio	Division of Maternal and Child Health	Director of Maternity Services Director of Family Planning Field Services 1 Staff Assistant 7 Family Planning Coordinators MCH Director		X	X	X ①
Oklahoma*	Maternal and Child Health Division	1 Public Health Nurse 1 Public Health Statistician 1 Social Work Consultant 1 Psychological Consultant 1 Nutritionist 3 Social Workers 1 Social Worker		X	X	X
Oregon	Maternal and Child Health Section, Office of Preventive Medical Services	1 Public Health Physician (Project Director) 1 Public Health Educator 1 Information Representative 1 Executive Assistant 2 Public Health Nurses 1 Public Health Educator 1 Nutrition Consultant		X	① X	① X X

Table 27 (Continued).

Administration of State Health Agency Family Planning Programs

X = Headquarters staff ① = Field staff

State	Agency Responsible for Family Planning	Number and Title of Professional Staff	Time Devoted to Family Planning			
			Less than 10%	10% to 25%	25% to 50%	Full Time
Virginia	Bureau of Family Planning	1 Family Planning Director 1 Information Officer				X X
Virgin Islands*	State Health Agency	4 Obstetricians 8 Nurse Mid-wives 3 Health Aides 2 Social Aides		①		① ① ①
Washington	Community Services Unit	Coordinator (Medical Doctor) 1 Administrative Assistant 2 Public Health Nurses 1 Fiscal Officer		X	X X X	
West Virginia*	Division of MCH	1 Project Director 1 Obstetrician-Gynecologist 2 Health Educators 1 Social Worker 1 Licensed Practical Nurse 2 Obstetrician-Gynecologist Consultants		X		X X X X
Wisconsin	MCH Section, Bureau of Community Health Services	Director of Community Health Services MCH Section Chief 2 Public Health Educators 1 Public Health Nurse	X		X	
Wyoming	Wyoming Department of Health and Social Services	Department Administrator 1 MCH Nursing Consultant	X X			X X
		Total	116	97	66	130**
		Less locally assigned personnel	78	21	14	38
		Subtotal (Headquarters' Personnel)	38	69	52	92**

* Agency personnel listed include some clinical or field staff assigned to family planning. Other states which may have some clinical or field staff assigned to family planning may not have reported them in the CFPD survey.

** One headquarters professional in Colorado is assigned 75 percent time; another in Maryland is assigned 65 percent.

their service programs nevertheless include referral and/or purchase of voluntary sterilization services for men and/or women. Seven states (Kansas, Kentucky, Maryland, New Hampshire, Oklahoma, South Carolina, and Tennessee) and the District of Columbia and the Virgin Islands have health policies or programs which encompass both referrals and purchase or provision of sterilization services for men and women; of these, all but Kansas have written policies. Seven states (Alabama, Colorado, Hawaii, Idaho, New Jersey, Oregon, and Washington) have policies or programs which encompass referrals of both men and women to voluntary sterilization services; among these states, Alabama *purchases* services for women only, and Idaho purchases on behalf of men only; Alabama, Hawaii, New Jersey and Washington have written policies. Only Connecticut, Pennsylvania and West Virginia have written policies prohibiting the purchase of voluntary sterilization services. Connecticut and West Virginia also prohibit referral for voluntary sterilization services.

Welfare agencies of states and federal jurisdictions have even fewer written policies on voluntary sterilization. Only five states (Connecticut, Georgia, Hawaii, New Hampshire, and Washington) have such policies. Georgia, Hawaii, New Hampshire and Washington require or authorize both referral for and purchase of voluntary sterilization services for eligible welfare recipients by local welfare agencies. Connecticut's policy prohibits referral and purchasing. Forty-five states and three federal jurisdictions have no written welfare policies on voluntary sterilization; no information was available for Guam; American Samoa has no welfare program (see Table 29).

Despite the fact that most welfare agencies do not have written agency policies on voluntary sterilization, many have general medical referral or purchase provisions in their welfare policies or in their social service programs which they appear to apply to voluntary sterilization services. Eighteen welfare agencies require, recommend or authorize both referral to and purchase of voluntary sterilization services by local welfare agencies⁴⁴ (see Table 29); only four (Georgia, Hawaii, New Hampshire, and Washington) have written policies on voluntary sterilization. Five states (Alaska, New Mexico, Rhode Island, South Dakota and Tennessee), and the District of Columbia require, recommend or authorize referral to voluntary sterilization services but have no provisions regarding the purchase of services. Eleven states leave referral policy to local welfare agencies. Among these, California does not authorize purchasing; Maryland, Nebraska, North Carolina, South Carolina, Texas and Wyoming authorize or recommend purchase of services; Maine, Mississippi, New

Jersey and Virginia apparently have no purchase of services policies applicable to voluntary sterilization services. Connecticut and Utah *prohibit referral for and purchase of* voluntary sterilization services by local welfare agencies.

Footnotes to "State Health and Welfare Policies on Family Planning and Voluntary Sterilization"

1. Federal jurisdictions included in this study are the District of Columbia, Guam, Puerto Rico, American Samoa, and the Virgin Islands.
2. Puerto Rico indicated in the CFPPD survey that it has a written welfare family planning policy, but did not furnish a copy of the policy. No information is available for Guam, and American Samoa has no welfare program.
3. Colorado, Iowa, Missouri, Nebraska, New Mexico, South Dakota, Texas, Vermont, Wisconsin, Wyoming.
4. Title IV-A directs states to develop plans and programs to secure family planning services for all "appropriate" recipients of Aid to Families with Dependent Children (AFDC) and to additional groups at the states' option.
5. For example, in the past two years, Arkansas, Illinois, Maryland, New Hampshire, New Jersey, Ohio, Oregon, Pennsylvania, Tennessee and Washington have all issued family planning manuals containing basic policies, medical standards, and program guidelines and procedures.
6. No information was available on the welfare program in Guam; American Samoa has no welfare program.
7. The following states neither recommend nor establish any specific eligibility requirements or patient fees, but indicate that such policies are determined by local agencies: Connecticut,* Indiana,* Iowa, Massachusetts,* Nebraska, New Jersey,* New Mexico, New York,* North Dakota,* Pennsylvania,* Vermont, Wisconsin and Wyoming. Although seven of these states (*) have general, written policies on family planning (see Table 2), these policies do not address themselves specifically to the question of eligibility.
8. California, Colorado, Florida, Maryland, Mississippi, New Hampshire, Oregon, Rhode Island, Tennessee and West Virginia.
9. Alaska, Arkansas, Connecticut, Delaware, Georgia, Guam, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Dakota, Puerto Rico, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming.
10. Arizona, California, Kentucky, Maryland, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, and Washington.
11. Alabama, Florida, Maine, Michigan, Mississippi, Nevada, New Hampshire, Oklahoma, Pennsylvania, and West Virginia. Among these, Nevada is the only state which accords first priority to welfare recipients.
12. The Department indicated in the CFPPD survey that where Public Health Service Act Title X funds are utilized, it will recommend that services be provided free to families of four earning less than \$5,000 annually (with \$50 added to the ceiling for each additional child) and that charges be made on a sliding fee scale for patients with highest incomes.
13. Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Texas, Utah, Virgin Islands, Virginia, Washington, West Virginia and Wyoming.

Footnotes continue on p. 128 ff. Tables 28 and 29.

Table 28. Administration of State Welfare Agency Family Planning Programs

X = Headquarter staff ① = Field staff

State	Agency or Agencies Responsible for Family Planning	Number and Title of Staff	Time Devoted to Family Planning			
			Less than 10%	10% to 25%	25% to 50%	Full Time
Alabama	Bureau of Family and Children's Services	None				
Alaska	Division of Family and Children's Services	None				
Arizona	Family and Child Welfare Services Division	1 Consultant		X		
Arkansas	No special agency or unit Department of Public Welfare	None				
California	Family Services Bureau	1 Social Service Consultant				X
Colorado	Family and Children's Services Section	1 Consultant, Unmarried Parents		X		
Connecticut	Bureau of Health Services Division of Child and Family Services	None				
Delaware	Bureau of Family Services	None				
District of Columbia	Bureau of Social Services and Resources	1 Family Planning Consultant				X
Florida	Division of Family Services	None				
Georgia	Family Planning Section	1 Family Planning Chief 3 Family Planning Representatives				X X
Guam	No Response					
Hawaii	Office of Medical Care Administration Program Development Office — Family Services	1 Med. Care Administrator 1 Family Serv. Adminis. 1 Med. Welfare Specialist 1 Field Services Rep. 1 Medical Consultant	X X X X X			
Idaho	Division of Family and Children's Services	None				
Illinois	Division of Program Development Division of Medical Services	None				

	Children's Division	6 Consultants			
Indiana	Bureau of Family and Children Services	1 Family Life and Family Planning Specialist			X
Iowa	Community Service Division	None			X
Kansas	No special agency or unit	None			
Kentucky	Department of Social Welfare	None			
Louisiana	Division of Field Services	None			
	Division of Services to Families and Children	None			
Maine	Social Services Unit	2 Social Serv. Consultants	X		
Maryland	Social Services Administration	1 Spec., Serv. to Families with Children	X		
		1 Spec., Single Parents Services	X		
Massachusetts	Office of the Assistant Commissioner for Social Services	1 Asst. Commissioner	X		
		1 Dir. of Spec. Services		X	
		1 Program Development Specialist			X
Michigan	Division of Basic Services	1 Dir. of Basic Services	X		
Minnesota	Program Development Unit	1 Family Planning Spec.			X
Mississippi	Family and Children's Services Unit	1 Program Coordinator	X		
Missouri	No special agency or unit	None			
	Division of Welfare	None			
Montana	Division of Social Services	None			
Nebraska	Division of Social Services	1 Division Chief	X		
	Division of Medical Services	1 Med. Worker Consultant	X		
Nevada	Family and Children's Services Unit	1 Unit Chief	X		
		1 Family Services Spec.	X		
		1 Title XIX Specialist	X		
New Hampshire	Bureau of Medical Services	1 Asst. Dir. of Med. Ser.	X		
		1 Chief of Soc. Wel. Serv.	X		
		1 Asst. Dir. of Social and Rehabilitation Ser.	X		
New Jersey	Bureau of Social and Rehabilitation Services	None			
	Bureau of Social Services	None			
New Mexico	Social and Rehabilitation Services Division	None			
	Medical Assistance Division				

Table 28 (Continued).

Administration of State Welfare Agency Family Planning Programs

X = Headquarter staff ① = Field staff

State	Agency or Agencies Responsible for Family Planning	Number and Title of Staff	Time Devoted to Family Planning			
			Less than 10%	10% to 25%	25% to 50%	Full Time
New York	Office of Medical Program Development Office of Social Services Program Development	1 Social Ser. Consul. (Med.) 1 Social Ser. Consul. (Med.) 1 Deputy Com. for Med. Program Development 5 Area Med. Consultants 5 Area Office Supervisory Medical Social Workers	X	X ① ①		①
North Carolina*	Family and Children's Services Section	1 Supervisor of F.P. Ser. 1 Supervisor of Family Services Unit 10 Commu. Ser. Consultants 11 Family Services Consul.		X ① ①		X
North Dakota Ohio	Social Services Unit Division of Social Services	None 1 Service Coordinator 1 Program Dev. Spec. 1 Tech. Asst. Spec.		X X X		
Oklahoma Oregon	Medical Assistance Division Bureau of Children's Services Family and Children's Services Division Medical Assistance Section Adult Services Section	2 Professional Staff None	X			
Pennsylvania Puerto Rico	Bureau of Family and Child Welfare No special agency or unit Department of Social Services	1 Director, Bureau of Family and Child Welfare 1 Director of F.P. 1 Demographer 1 Marriage Counselor 1 Social Service Technician	X			X X X X
Rhode Island Samoa	Family and Children's Services Section No welfare program	None				
South Carolina	Children and Family Services Division	6 Consultants 2 Staff Developers	X	X		

State	Agency	None				
South Dakota	Medical Administration Service Administration					
Tennessee	Division of Social Services	1 Program Specialist, Family Planning Services				X
Texas	Social Service Division Medical Service Division	None				
Utah	Division of Family Services	None				
Vermont	No special agency or unit Department of Social Welfare	None				
Virginia	Bureau of Family and Children's Services	1 Child Welfare Specialist				X
Virgin Islands	Division of Child and Family Services	2 Health Aides 1 Dir., Child & Fam. Ser. 1 Exec. Asst. to the Commissioner	X X			X
Washington	Office of Social Services Family and Children's Section Adult Services Section	1 Program Specialist 1 Family Services Spec.		X		
West Virginia	Division of Social Services	1 Division Director	X			
Wisconsin	Division of Family Services	1 Social Ser. Plan. Spec. 2 Staff Dev. Spec.	X X			
Wyoming	Division of Public Assistance and Social Services	1 Family Ser. Specialist		X		
	Total		39	46	2	18**
	Less Field Staff			31		
	Subtotal (Headquarters' Staff)		39	15	2	18**

* Agency personnel listed include some clinical or field staff assigned to family planning. Other states which may have some clinical or field staff assigned to family planning may not have reported them in CFPD survey.

** One professional is assigned 75 percent time to family planning in each of the state offices in New York and Virginia.

Table 29.

Voluntary Sterilization Policies

State or Federal Jurisdiction	Health Agencies ^a			Welfare Agencies [†]		
	Written Policy	Referral to Services	Purchase of Services	Written Policy	Referral to Services	Purchase of Services
Alabama	Yes	Men/Women	Women only	No	Authorized	
Alaska [#]	No	—	—	No		
Arizona	Yes ¹			No		
Arkansas	No			No		
California [#]	No	Men/Women		No	Local Option	Not Authorized
Colorado [#]	No	Prohibited	Prohibited	No	Authorized	Authorized
Connecticut	Yes			Yes ²	Prohibited	Prohibited
Delaware	No	Men/Women	Men/Women	No	Authorized	Authorized
District of Columbia [#]	Yes ³			No		
Florida	No			No		
Georgia [#]	No			Yes	Required	Required
Guam	(No Information)			(No Information)		
Hawaii	Yes	Men/Women	—	Yes	Required	Required
Idaho	No	Men/Women	Men Only	No	Required	Required
Illinois [#]	No			No	Required	Required
Indiana	No			No		
Iowa [#]	No			No		
Kansas [#]	No	Men/Women	Men/Women	No	Required	Required
Kentucky	Yes	Men/Women	Men/Women	No	Authorized	Authorized
Louisiana	(No information)			No		
Maine	No			No		
Maryland	Yes	Men/Women	Men/Women	No	Local Option	Authorized
Massachusetts	No			No	Local Option	Authorized
Michigan [#]	No			No	Authorized	Authorized
Minnesota	No			No	Authorized	Authorized
Mississippi	(No Information)			No	Required	Required
Missouri	No			No		
Montana	No ⁴			No	Local Option	Recommended
Nebraska	No			No	Recommended	Recommended
Nevada	No			No	Authorized	Authorized
New Hampshire	Yes ⁵	Men/Women	Men/Women	Yes	Authorized	Authorized
New Jersey	Yes	Men/Women	—	No	Local Option	
New Mexico	No ⁶			No	Required	
New York	No			No		
North Carolina	No			No	Local Option	Recommended
North Dakota	No			No	Authorized	Authorized
Ohio [#]	No			No	Required	Required
Oklahoma [#]	Yes	Men/Women	Men/Women	No ⁷		
Oregon [#]	No	Men/Women	Men/Women	No	Authorized	Required

	Yes ⁸	—	Prohibited	No	Required	Required
Pennsylvania	No			No		
Puerto Rico	No			No	Authorized	
Rhode Island	(No Information)			No		
Samoa				(No welfare program)		
South Carolina	Yes	Men/Women	Men/Women	No	Local Option	Recommended
South Dakota	No			No	Recommended	
Tennessee [#]	Yes ⁹	Men/Women	Men/Women	No	Required	
Texas	No			No	Local Option	Authorized
Utah	No			No ¹⁰	Prohibited	Prohibited
Vermont	No			No		
Virginia	No			No	Local Option	
Virgin Islands	Yes	Men/Women	Men/Women	No		
Washington	Yes	Men/Women	—	Yes	Required	Required
West Virginia	Yes ¹¹	Prohibited	Prohibited	No		
Wisconsin	No			No		
Wyoming [#]	No			No	Local Option	Authorized

* The table indicates whether the health agency has a written policy on voluntary sterilization and whether the policy encompasses referral to and/or purchase (or provision) of voluntary sterilization services for men and/or women. In many cases health agencies do not have a written policy, as such, but their service programs do include referral and/or purchase of voluntary sterilization services.

† The table indicates whether the welfare agency has a written policy on voluntary sterilization and whether the policy requires, recommends, authorizes, leaves to local option, or prohibits referral to and/or purchase of voluntary sterilization services by local welfare agencies. In many cases welfare agencies do not have official, written policies on voluntary sterilization as such; instead, they seem to apply general medical referral and/or purchase policies to voluntary sterilization services.

Among the seventeen states and the District of Columbia which have affirmative statutes on family planning services, thirteen states and the District appear to include sterilization as a means of family planning either explicitly in the statute or as a result of administrative interpretation (see the section on Statutes and Case Law).

¹ The policy states that "efforts should continue . . . to discuss and make available voluntary sterilization for men and women."

² However, the state welfare agency reported in the CFPD survey that since October 1971 voluntary sterilization is no longer illegal in Connecticut and this event "may change agency policy in this regard."

³ "Sterilizations are performed in accordance with the accepted standards of medical practice," according to the District's family planning policy.

⁴ Individual programs have funds in their budgets to purchase voluntary sterilization services, referrals and counseling, according to the state health agency.

⁵ The Division of Public Health Service's family planning program manual contains guidelines for counseling of men and women regarding sterilization and indicates that a small amount of public funds is available for services.

⁶ Although the Medical Services Division has no written policy, local health offices are authorized to provide information on sterilization upon patient request, according to the CFPD survey.

⁷ The Department of Institutions, Social and Rehabilitative Services reported in the CFPD survey that it "does not provide [sterilization] services."

⁸ According to the Department of Health's family planning program guidelines, state health agency funds cannot be used for "any surgical procedures, including abortions and sterilizations. . . ."

⁹ According to the state health agency's "Rules and Regulations" for family planning services (which quote the state's 1971 statute on family planning), "contraceptive procedures, including medical procedures for permanent sterilization, when performed by a physician on a requesting and consenting patient, are consistent with policy."

¹⁰ The Department of Social Services reported in the CFPD survey that sterilization procedures are "illegal" in Utah.

¹¹ State Department of Health Policy rules out voluntary sterilization as an "acceptable means of family planning," according to the CFPD survey.

14. Nine of these states—Connecticut, Florida, Indiana, Mississippi, Nevada, New Hampshire, South Dakota, Tennessee and Wisconsin—do not have any administrative or fiscal responsibility for GA programs which are locally operated. However, three of these states, Alabama, Maine and New Mexico, did not report policy provisions relating to referral of GA recipients for family planning in the CFPPD survey, despite the fact that they have some responsibility for GA programs. (Information on state administration of GA is from American Public Welfare Association, 1971 *Public Welfare Directory*, The Public Welfare Directory, Vol. XXXII).
15. Connecticut, Indiana, Iowa, Massachusetts, Minnesota, Nebraska, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Vermont, Wisconsin and Wyoming.
16. Those 14 states in which the health agency leaves eligibility determination to local agencies are not included in the comparison. Conceivably some local health agency requirements in a given state might conflict with state welfare requirements while other local requirements do not.
17. A more "restrictive" policy in this context means a policy which places greater limitations or qualifications on the eligibility of a given category of individuals for family planning services. For example, a policy which requires an adult to have one or more children in order to be eligible is more restrictive than one which does not.
18. The Kansas health agency requires that all adults be married or referred by a physician; this could exclude unmarried categorical welfare recipients.
19. As noted above, 14 state health agencies leave the determination of eligibility policies to local agencies; no information is available for American Samoa.
20. "Consent," as used here, means the permission or authorization of a parent, guardian or other individual or agency legally authorized to act in *loco parentis* to permit the giving of medical family planning services to a minor. It is assumed throughout that such services to a minor always require the consent of the minor.
21. Arizona, Arkansas, Delaware, Florida, Maine, Missouri, Montana, Nevada, North Carolina, Oklahoma, Pennsylvania and the Virgin Islands.
22. Hawaii, Kentucky, Louisiana, South Dakota, Texas and Utah.
23. Arkansas, Delaware, Guam, Idaho, Maine, Missouri, Montana, Nevada, Oklahoma and Puerto Rico.
24. Alaska, Arizona, Florida, Hawaii, Kentucky, Louisiana, North Carolina, South Dakota, Texas and Virgin Islands.
25. Idaho, Maine, Missouri, Montana, Oklahoma and Puerto Rico.
26. Alaska, Arizona, Arkansas, Delaware, Florida, Hawaii, Kentucky, Louisiana, Nevada, North Carolina, South Dakota, Texas and Virgin Islands.
27. J. Goldman and L. S. Kogan, "Public Welfare and Family Planning," *Family Planning Perspectives*, Vol. 3, No. 4, 1971, p. 22.
28. Alabama, Alaska, Arizona, Connecticut, Florida, Hawaii, Indiana, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Dakota, Tennessee, Utah, Virgin Islands, and Wisconsin.
29. Arizona, Indiana, Kentucky, Maine, Michigan, Mississippi, Missouri, Montana, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, and the Virgin Islands.
30. Alabama, Alaska, Arkansas, Florida, Hawaii, Kansas, Louisiana, New Hampshire, North Dakota, Puerto Rico, Rhode Island, South Carolina, and Utah.
31. Alabama, Alaska, Arizona, Arkansas, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, the Virgin Islands.
32. Alabama, Alaska, Arizona, Arkansas, Florida, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, the Virgin Islands.
33. Maternal and Child Health Service, Director's Letter MCH-70-2, May 12, 1970.
34. Maternal and Child Health Service, Director's Letter MCH-71-1, January 22, 1971.
35. American Samoa has no MCH program.
36. The allocation among states of nonearmarked MCH funds for FY 1971 represents the total MCH allocation by state minus the funds earmarked for family planning and funds for special projects. Data on estimated awards are from Director's Letter MCH-71-1, January 22, 1971.
37. Op. Cit., J. Goldman and L. S. Kogan, p. 28.
38. Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, West Virginia, Wisconsin.
39. Arizona, Colorado, Connecticut, Idaho, Illinois, Indiana, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Rhode Island, Vermont, Washington, Wyoming.
40. Alabama, Alaska, Arkansas, California, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin.
- 40a. Among these, Colorado and Maryland each reported one staff professional devoting 65 and 75 percent time, respectively, to family planning.
41. In some cases it is difficult to assess how many of the individuals involved in family planning activities are assigned directly to central administrative staffs of health agencies. A number of the small health agencies appear to have included in the CFPPD survey full- and part-time staff who may be employed in regional or field activities.
42. Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Idaho, Illinois, Kansas, Kentucky, Louisiana, Missouri, Montana, New Jersey, New Mexico, North Dakota, Oregon, Rhode Island, South Dakota, Texas, Utah and Vermont.
43. Alabama, Arizona, Connecticut, District of Columbia, Hawaii, Kentucky, Maryland, New Hampshire, New Jersey, Oklahoma, Pennsylvania, South Carolina, Tennessee, the Virgin Islands, Washington, and West Virginia.
44. Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Massachusetts, Michigan, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, and Washington.

A Note on Artificial Insemination

Artificial insemination which is now being utilized increasingly poses new legal problems in fields as diverse as legitimacy, inheritance, property rights, criminal law, negligence, and fraud. Most of these questions are as yet unanswered. There are no laws in the United States prohibiting artificial insemination, and there are very few relevant statutes or cases. Cases have arisen in only three states (New York, Illinois, and California) which directly or indirectly confront the issues involved in artificial insemination;¹ and only Arkansas, Georgia, Oklahoma, California and Kansas have enacted legislation on the subject of artificial insemination.²

In order to analyze the legal questions involved, one must distinguish the types of artificial insemination in common use today:

- homologous artificial insemination, or artificial insemination with the husband's semen (commonly termed A.I.H.);
- combined artificial insemination where the husband's semen is mixed with that of a donor (or donors) (commonly termed C.A.I.) and;
- heterologous artificial insemination or artificial insemination with semen of a third-party donor (commonly termed A.I.D.).

The first two types of artificial insemination (A.I.H. and C.A.I.) in general pose no legal difficulties. It is primarily A.I.D. which has raised a variety of legal questions—the precise questions being related to which persons' legal rights are involved:

A. With Respect to the Child:

(Assuming the mother is married)

- Is the child born via A.I.D. legitimate? Whose name should be on its Birth Certificate as father?
- Whether or not the child is legitimate, does the husband have an obligation to support the child: if he consented to the A.I.D.? if he acquiesced subsequently? if he objected?
- If there is a separation or divorce, does the husband have an obligation of support: if he consented to the A.I.D.? if he acquiesced subsequently? if he objected?
- If there is a divorce or separation, does the husband have visitation rights: if he consented? if he acquiesced subsequently? if he objected?

- Does the child have the right to inherit from the husband: if the husband consented? if he acquiesced? if he objected? Does the child have the right to inherit from the donor, the actual father?

- Is incest committed if a half-brother and half-sister, offspring of the same donor, who do not know they are related, marry?

B. With Respect to Husband and Wife:

(i.e., the mother of the child conceived via A.I.D.)

- Has the wife committed adultery? Does it matter if the husband consented? If the husband did not consent, is it grounds for divorce?
- If the wife conceives via A.I.D. and gives birth to a child, has her marriage been consummated for purposes of defending a claim for annulment of the marriage on grounds of nonconsummation?

C. With Respect to the Donor:

- Should he be considered the father for purposes of filling out the birth certificate? Can the child inherit from him? Is he liable for the support of the child? Does he have the right to visit the child? Has he committed or been accessory to adultery with the mother? Would he be considered guilty of statutory rape of the mother if she is under age?
- Can the donor be considered a participant in adultery from the standpoint of a divorce action?

D. With Respect to the Doctor:

- Can he be held civilly liable to the husband, wife or the child or the donor by reason of artificial insemination (aside from negligence)?
- Is he liable for perjury (or falsifying records) if he puts the husband's name on the birth certificate with knowledge that the husband is not the father?
- Has he committed or been accessory to adultery with the mother? Would he be considered guilty of statutory rape of the mother if she is under age?
- Can he be held liable for child support?

E. With Respect to Semen Banks:

- Can they be held responsible for possible incest?
- Can they be held liable for any other results of artificial insemination?

- Who owns the sperm upon the depositor's death? These questions can arise in terms both of civil and criminal liability; e.g. if the husband fails to support an A.I.D. child, is he criminally liable for violation of a support statute as well as civilly liable to the wife or the child?

Questions, not directly legal but which may bear on the legal implications of the artificial insemination process include:

- Who has the responsibility for choosing the donor for A.I.D.?
- Should the donor's identity be secret from wife and husband? from the inseminating doctor? from the doctor who delivers the child?
- Should the wife's identity be secret from the donor?
- Does the couple have the emotional and psychological stability to "qualify" for A.I.D.? Who decides this: Couple? Doctor? Board?
- Can incest be prevented by limiting the number of times a donor can donate his semen? Can there be a central record of this for doctors to check?

These problems can probably best be solved by legislation which would provide uniform answers to the numerous questions raised by artificial insemination, define the procedures to be followed, and establish the rights and responsibilities of the parties involved. No such comprehensive statute has yet been passed, but five states have made a start.³

Footnotes to "Artificial Insemination"

1. *United States Cases: Hoch v. Hoch*, Unreported, Cir. Ct., Cook Cty. Illinois (1948). *Strnad v. Strnad*, 190 Misc. 786, 78 N.Y.S. 2d 390 (Sup. Ct. 1948). *Doornbos v. Doornbos*, U.S. Law Week 2308 (No. 54-S-14981) Super. Ct., Cook Cty. Illinois (1954) app. dismissed 12 Ill. App. 2d 473, 139 N.E. 2d 844 (1956). *Gursky v. Gursky*, 89 Misc. 2d 1083, 242 N.Y.S. 2d 406 (Sup. Ct. 1963). *Anonymous v. Anonymous*, 41 Misc. 2d 886, 246 N.Y.S. 2d 835 (Sup. Ct. 1964).

People v. Sorensen, 66 Cal. Rptr. 7, 437 P. 2d 495 (1968). *Foreign Cases: Orford v. Orford*, 49 Ont. L. Rev. 15, 58 D.L.R. 251 (1921) (Canada). *Russell v. Russell* [1924] A.C. 687 (England). *L v. L*, [1949] 1 All E.R. 141 (England). *MacLennan v. MacLennan*, (1958) Sess. Cas. 105 (Scot.), 1958 Scots L.T.R. (Scots LAW Times Report) 12. *In re Carla Casarotti Faedda*, N.Y. Times, Feb. 17, 1959, p. 8. Also see *Il Tempo* (Rome), Jan. 15, 1960, p. 9.

Local Legislation: N.Y. City Health Code, art. 21 (1959) (formerly N.Y. City Sanitary Code 112).

2. *Enacted Legislation: Arkansas—Ark. Stat. Ann. § 61-141* (1971). *Georgia—Ga. Code Ann. § 74-101.1* (Supp. 1971); § 74-9904 (Supp. 1971). *Oklahoma—Okla. Stat. Ann. Title 10, §§ 551-553* (1971 Supp.). *California—Cal. Civil Code § 216* (1969 amendment); *Cal. Penal Code § 270* (1970). *Kansas—Kan. Stat. Ann. §§ 23-128-23-130* (Supp. 1970). *Proposed but Defeated Legislation: New York Senate Intr. No. 745 Pr. No. 2042* (1948) and similar bills in 1949, 1950, and 1951. *New York Senate Intr. No. 1882 Pr. No. 1922* (1964). *Virginia S. 746*, G.A. Sess. (Va. 1948). *Minnesota H. File No. 1090* (1949); *H. File No. 1091* (1949); *H. File No. 1092* (1949). *Wisconsin Bill 407* (1949).
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Section II

**Profiles: Laws and Health and Welfare Policies Relating to
Family Planning, Contraception, Voluntary Sterilization, and
Services to Minors, for Each State and Federal Jurisdiction**

Note: Each State Profile Is Arranged as Follows:

A. Laws Relating to Contraception

1. Affirmative laws establishing family planning programs
2. Laws relating to sale and distribution of contraceptives.
3. Laws relating to dissemination of information advertising and display with respect to contraceptives.
4. Laws relating to contraceptive services to minors.

B. Laws Relating to Voluntary Sterilization

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. Summary of Current Policy.
2. Eligibility for Service.
3. Administration of Program.
4. Financing of Program.
5. Voluntary Sterilization.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. Summary of Current Policy.
2. Referral and Purchase Provisions.
3. Eligibility for Service.
4. Administration of Program.
5. Financing of Program.
6. Voluntary Sterilization.

Alabama

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Alabama.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21.¹ However, Alabama has a comprehensive 1971 statute regarding the medical treatment of minors. This law provides that a minor who is 14 years of age or older, or who has graduated from high school, or is married, or having been married is divorced, or is pregnant or has borne a child may give effective consent to any legally authorized medical or health services. Act No. 2281 (1971).

Any legally authorized medical, health or mental health service may be rendered to a minor of any age without the consent of parent or guardian in emergencies—that is, “when, in the physician’s judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor’s life, health or mental health.”

The 1971 law also provides that minors of any age may consent to medical or health services to determine the presence of or to treat pregnancy or venereal disease.

Moreover, “the consent of a minor who professes to be but is not a minor whose consent alone is effective to medical . . . or . . . health services shall be deemed effective without the consent of the minor’s parent or legal guardian, if the physician or other person relied in good faith upon the presentations [sic] of the minor” and “[a]ny physician or other person who has relied in good faith upon the representations of any persons under any of the provisions of the above said Act or who acts in good faith under any of the provisions of the above said Act shall not be liable in law or equity for not having consent.”

Footnotes:

1. *Hutchinson v. Till*, 212 Ala. 64, 101 So. 676 (1924). A married person, widow or widower of 18 or over is relieved of the disabilities of minority. Ala. Code tit. 34, § 76 (1959); tit. 34, § 76 (1) (Cum. Supp. 1969). By statute in Alabama, minors older than 18 can be relieved generally by the

circuit court of the disabilities of minority, upon request of a parent, or when the parents are dead, or if a parent is living but is insane or has abandoned the minor for one year. Ala. Code tit. 27, § 13 (1958).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The CFPPD survey indicates that the Department of Public Health has a policy on voluntary sterilization which encompasses referrals for men and women who wish it and payment for or provision of services to women only. (See Health Policy section below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The only written policy on family planning of the Alabama Department of Public Health consists of a series of recommendations made by the Advisory Council for Comprehensive Health Planning and subsequently approved by the State Board of Health in April and August 1970. The policy places high priority on services to indigent women of childbearing age and urges uniform services for women throughout the state without regard to geographical considerations. In the policy it is recommended that “special efforts should be directed to encourage legislation to . . . permit physicians to treat VD, prescribe contraceptives, and provide prenatal care to minors without requirement to notify parents or obtain parental consent.” The policy also recommends that public agencies providing family planning “should be encouraged to direct special attention to the prevention of illegitimate births.” It is further recommended that “individual public and private agencies concerned with over-population should be encouraged to emphasize educational programs calling for the voluntary limitation of families to not more than three (3) children.”

2. *Eligibility:* The Department of Public Health reported in the CFPPD survey that social eligibility requirements are recommended by the state but are determined by local health agencies. It is recommended that all categories of adults and minors including never married, never pregnant minors

without parental consent be considered eligible for family planning services. No financial eligibility requirements are specified by the Department, though services to the poor without regard to geographical considerations are stressed in the written policy cited above.

3. *Administration*:¹ The Bureau of Maternal and Child Health has administrative responsibility for family planning services in the Department of Public Health. Bureau staff assigned to family planning activities include: one medical doctor, 10–25 percent time; one registered nurse, 10–25 percent time; one registered nurse, full-time; and three secretaries, 10–25 percent time. Some clinicians and nurses who work part-time in the county health department are paid by the Bureau of Maternal and Child Health. The Bureau performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs.

4. *Financing*:² \$212,556 of new Maternal and Child Health (MCH) funds which were federally earmarked for family planning were allocated to the Department of Public Health in FY 1971. Of these funds, \$202,203 or 95 percent were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds in FY 1971 was \$1,077,593. An estimated \$91,000 of these funds were spent for family planning services. The Department received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Department for family planning services.

5. *Voluntary Sterilization*: The Department of Public Health reported in the CFPPD survey that it has a policy on sterilization which encompasses referrals for men and women who wish it and purchase or provision of services for women only.

Footnotes:

1. Information on administration and state financing of family planning services was reported by the state health agency in the CFPPD survey.

2. Information on federal allocations of MCH funds is from Director's Letter MCH-71 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Alabama is contained in Section C of the *Manual for Administration of Service for Children and Their Families* issued by the State Department of Pensions and Security. Family planning is covered in an undated, six-paragraph

subsection which states that "Family planning is designed to assist individuals with knowledge and means of controlling the size of the family consistent with their personal desires. Family planning programs can be a resource for identifying health problems, reducing the possibilities of children being born with serious physical and mental defects, avoiding unwanted pregnancies and preventing some of the causes of family breakdown."

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Pensions and Security *recommends* that county welfare departments *refer* public assistance recipients to medical family planning resources. Section C of the *Manual* provides that county departments also have the "responsibility to assist individuals in getting to clinics, check on appropriate clinic dates, and help arrange for transportation or plans for the care of children in the individual's absence." However, the Department and local welfare agencies *do not purchase* medical family planning services for eligible public assistance recipients.² According to the *Manual*, "Family planning clinics are operated by the State Health Department in all 67 counties. These clinics provide medical and/or nursing consultation, educational services, supplies, as well as follow-up services." The Department reported that there is an "informal agreement with the State Health Department" for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as applicants, past recipients, potential recipients of such assistance and residents of low-income areas are eligible for referral services only. General Assistance recipients are not eligible for referral services.

There are no additional limitations that affect the provision of services to adults, but the Department reported that "Criteria for eligibility [for medical services] is determined by the Health Department." Under the welfare policy, parental consent is required for the provision of services to minors. The *Manual* states that "An appropriate individual is considered by the Department to be an adult, or a minor whose parent (s), guardian or legal custodian requests, or gives consent that this service be provided."

4. *Administration*:⁴ The Bureau of Family and Children's Services in the State Department of Pensions and Security has administrative responsibility for the family planning program. Its family planning activities are mainly confined to the training of local welfare staff. The Bureau has no full or part-time family planning staff.

5. *Financing*:⁵ The Department of Pensions and Security received no appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Pensions and Security has no written policy on voluntary sterilization, and the CFPPD survey indicated that the Department does not refer eligible persons for sterilization procedures.

Footnotes:

1. Information in this section was reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971, states that under the Alabama Medicaid program, family planning services are "not provided." However, this publication is based on data as of January 1970 and the Alabama Medicaid Program may have been modified since that date. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)

3. Information as reported in CFPPD survey.

4. Ibid.

5. Ibid.

Alaska

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Alaska has a statute which directs the State Department of Health and Welfare to prepare and distribute information on "planned parenthood" to public hospitals, clinics and health facilities, and where requested by them, to distribute "planned parenthood" information to private hospitals, clinics and health facilities. The Department is also obligated to advertise the availability of "planned parenthood" information and to distribute it to any person upon written request. Alaska Stat. § 18.05.035 (1969). This statute relates only to information and not to provision of services or supplies.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* Any person at 19, and any female, upon being married, is considered to have arrived at majority. Alaska Stat. §§ 25.20.010, 25.20.020 (1965).

Marriage may be contracted by males at the age of 19 and females at age 18. Alaska Stat. § 25.05.011 (1971 Cum. Supp.). Males at 18 and females at 16 may be issued a marriage license if they have written parental consent. A marriage license may be issued to males younger than 18 or females younger than 16 if the female is pregnant and if there is parental consent and a medical certificate stating that the female is pregnant. Alaska Stat. § 25.05.171 (1965).

There is statutory authority for examinations and treatment without parental consent of any minor for venereal disease and for examination without parental consent of female minors over 15 "with regard to pregnancy." Alaska Stat. § 09.65.100 (1971 Cum. Supp.). The words "female minor over the age of fifteen years" have been interpreted to mean any female who has passed her fifteenth birthday.¹ Op. Atty. Gen. AS 09.65.100 (Sept. 19, 1969).

We have found no cases indicating whether Alaska courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies and where the minors are "emancipated" or whether Alaska would accept the "ma-

ture minor doctrine" referred to in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

Under Alaska law, it is a misdemeanor for a parent or guardian of a child younger than 16 to wilfully fail, without lawful excuse, to furnish "necessary medical attendance" to the child. Alaska Stat. § 11.35.010 (1965).

The Department of Health and Social Services or a local government health or social services agency has authority to take action, in accordance with law, which may be necessary "to insure the proper care and protection" of a child younger than 16 who has been neglected and whom the Department has learned about from reports filed in accordance with the provisions of Alaska Stat. § 47.17.020 (1971 Cum. Supp.).² "Neglect" means the failure to provide, among other things, necessary medical attention for a child. Alaska Stat. § 47.17.070 (5) (1971 Cum. Supp.).

As stated under "Laws Establishing Family Planning Programs," above, Alaska by statute provides for the distribution of information relative to family planning by the Department of Health and Welfare to "any person." This appears to include minors. Since information only is dispensed, no question of parental consent apparently arises under this statute (See "Welfare Policy," "Eligibility").

Footnotes:

1. Ambiguity arose as to whether the statutory language required that a female minor be 16.

2. "Those who in the performance of their professional duties have cause to believe that a child has suffered harm as a result of abuse or neglect shall report the harm immediately." § 47.17.020.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

We have seen that Alaska has a statute providing for the distribution of information on "planned parenthood" by the Department of Health and Welfare (See Laws Establishing Family Planning Programs, above.) It is not clear whether this includes voluntary sterilization. However, the CFPPD survey indicates that the Social Services Division authorizes referral for voluntary sterilization procedures by

local welfare agencies of eligible public assistance recipients who wish it (See Welfare Policy Section below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Alaska Division of Public Health policy on family planning is contained in a *Policy Statement on Family Planning* promulgated by the Department of Health and Social Services on July 5, 1966. The policy sets forth the requirements for the development of informational materials on family planning by the Maternal and Child Health Section, and for distribution of these materials by the Health Education Unit of the Division of Public Health. The policy describes eligibility standards for receipt of information materials, and standards for referral of potential patients to medical authorities. Freedom of conscience and choice are guaranteed to public employees and potential family planning patients.

2. *Eligibility:*¹ "Information shall be provided upon written request to any person. It shall be provided upon verbal request to any married person or mother, to any person referred for such by a physician, or as part of premarital counseling," according to the 1966 policy cited above. However, the Division reported in the CFPPD survey that the Division of Public Health neither establishes nor recommends specific eligibility requirements or patient fees for family planning medical services; however, federal requirements will be satisfied in order to use federal family planning funds, according to the Division. Apart from official health agency policy, however, the following eligibility standards are applicable to family planning services: All categories of adults are eligible for family planning information. Only married minors are eligible for family planning information without consent, although the Chief of Child Health indicated in the CFPPD survey that "practice is evolving to provide information and education to anyone," regardless of marital status.

This account of applicable eligibility requirements reported by the Division of Public Health in the CFPPD survey contrasts with state law. By statute, Alaska provides for the distribution of family planning information by the Department of Health and Welfare to "any person." (See Laws on Contraception above.)

3. *Administration:*² The Child Health Section has administrative responsibility for family planning services in the Division of Public Health, Department of Health and Social Services. Professional staff assigned to family planning activities include the chief of child health, 10–25 percent time; one secretary, 10–25 percent time; one family planning nurse supervisor, full-time. The state health agency performs the following functions in support of family

planning activities: consultation; training; development and distribution of public educational materials; limited purchase or provision of supplies, equipment or other materials to local family planning programs; assistance with community organization for local family planning groups; grants to local family planning programs in support of services.

4. *Financing:*³ The amount of new MCH funds allocated to the Division of Public Health in FY 1971 which were federally earmarked for family planning was \$8,615. All of these funds were obligated for family planning activities. The total allocation to the state of non earmarked MCH funds in FY 1971 was \$177,000. An estimated \$1,985 of these funds were spent for family planning. The state health agency received a \$24,600 appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the state health agency for family planning services.

5. *Voluntary Sterilization:* The Division of Public Health has no written policy with regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information on administration and state financing of family planning services was reported by the state health agency in the CFPPD survey.
3. Information on federal allocations of MCH funds is from Director's Letter MCH-71-1 (Maternal and Child Health Services, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Alaska is contained in the Division of Social Services Staff Manual under Section 3500, "General Program Operations, Planned Parenthood," dated September 16, 1966. Subsection 3510 states that "Alaska Statute 18.05.035 authorized a program of planned parenthood, and the Division of Public Welfare has an important role in implementing this statute." Subsection 3510 further states that the role of the Division of Social Welfare includes the following:

1. Distribution of literature on planned parenthood, and
2. Referral of persons to the Division of Public Health facilities, U.S.P.H.S. facilities, or to private physicians for further information on planned parenthood.

The family planning policy of the Bureau of Indian Affairs is quoted in subsection 3512 of the policy. The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Division of Social Services *requires* local welfare agencies to *refer* eligible assistance recipients to medical family planning services. Although the policy is not clear on this point, it would appear

that public facilities such as United States Public Health Service hospitals and clinics and those of the Alaska Division of Public Health are expected to provide the necessary medical services.² Only in the absence of a government facility or physician or in unusual circumstances will the Social Services Division pay for family planning services. There is no single, standard state-wide reimbursement rate for medical family planning procedures. The Division of Social Services has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance, as well as applicants, past recipients, potential recipients of such assistance and residents of low-income areas are eligible for referral to family planning services and, as indicated above, in isolated instances the Division of Social Services will pay for medical services. General Assistance recipients are also eligible for family planning services. Subsection 3511 states that "Information shall be provided upon *written* request to any person. It shall be provided upon *verbal* request to any married person or mother, to any person referred for such by a physician, or as a part of premarital counseling. Additional counseling and assistance may be offered at the discretion of the employee concerned. Department personnel should initiate discussion of family planning when it appears a family may have need for or could benefit from such services. If a woman is believed to have a mental or physical disorder which would become more severe or would endanger

her life if pregnancy occurred, she would be referred to appropriate medical authority." The Social Services Division reported that it requires parental consent for the provision of services (as distinct from information) to all minors, except those that are married.

4. *Administration:*⁴ Administrative responsibility for the welfare family planning program is not assigned to any particular subdivision in the Division of Social Services. Activities are confined to the training of local welfare staff and the distribution of educational materials. The Division has no full- or part-time family planning staff.

5. *Financing:*⁵ The Department of Health and Social Services received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Health and Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Social Services Division authorizes local welfare agencies to refer eligible public assistance recipients who wish it, for sterilization procedures.

Footnotes:

1. Information in this section was reported by the state welfare agency in the CFPPD survey.
2. Alaska has not established a Medicaid program.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Arizona

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Arizona has no law establishing a state family planning program.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Arizona has a statute making it a misdemeanor to "write, compose or publish a notice or advertisement of any medicine or means . . . for the prevention of conception," or to offer one's services "to assist in the accomplishment of any such purpose. . . ." Arizona Rev. Stat. Ann. § 13-213 (1956).

This statute was construed in *Planned Parenthood Committee of Phoenix, Inc. v. Maricopa County*, 92 Ariz. 231, 375 P. 2d 719 (1962) and upheld as a valid exercise of the state's power, to protect the public health, safety or welfare.

However, the court held that the words of the statute ("advertising," "notice," "publish") were limited to formal announcements utilizing newspapers or similar mass media and publicly advocating specific trade branded contraceptive devices or preparations. The "dissemination of birth control information by a doctor to his patient or by the Planned Parenthood Committee to those who seek such information from them" was held not within the purview of the statute since such person to person dissemination is not "advertising." Some other situations held by the court not to be "advertising" include: articles, editorials and press releases in newspapers and periodicals on matters of general public interest which mention no trade names; Planned Parenthood leaflets or pamphlets placed on display racks in clinics or hospitals relating to desirable and safe methods of contraception but without referring to brand names or trademarks; referrals by doctors to the Planned Parenthood Committee. (Although the court said that if Planned Parenthood sent out canvassers actively to seek referrals to Planned Parenthood, this would be considered advertising.)

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 18. Ch. 146, Laws 1972 (effective May 5, 1972). However, by statute, emancipated and married minors can consent to medical and surgical treatment. Subsequent annul-

ment or divorce does not deprive a person of adult status once attained. Ariz. Rev. Stat. Ann. § 44-132 (1967).

"Males under eighteen or females under sixteen years of age shall not marry." Ariz. Rev. Stat. Ann. § 25-102 (1956).¹ Before the age of majority was lowered to 18, Arizona law required males younger than 21 and females younger than 18 to have parental consent before they could be issued a marriage license. Ariz. Rev. Stat. Ann. §§ 25-122, 25-128 (1956). Presumably now only those younger than 18 need parental consent.²

A minor is emancipated from the custody, care and control of his or her parents upon marriage or entering into the military service. *Crook v. Crook*, 80 Ariz. 275, 296 P. 2d 951 (1956). While there appear to be no other Arizona court decisions in point, the Attorney General has stated that: 1) in cases other than marriage or military service no single factor alone will establish emancipation; 2) proof of emancipation must include evidence that the parents have relinquished all control and authority over their child; 3) emancipation is never presumed and must be established by proof that is clear, cogent and convincing. Moreover the Attorney General has recognized that emancipation may be either complete or partial. Complete emancipation entirely severs the parental relationship so far as legal rights and liabilities are concerned. Partial emancipation "frees the child for only a part of the period of its minority, or from only a part of his parents' rights or for some special purpose, such as the right to earn and spend wages." Arizona Dept. of Law Opinion No. 69-27 (R-99), Oct. 10, 1969.

Arizona also has a statute which provides that in cases of emergency, when parents cannot be located after reasonable efforts, consent for emergency medical care may be given by the person standing in loco parentis to the minor requiring care. Ariz. Rev. Stat. Ann. § 44-133 (1967).

A minor of any age who may have contracted a venereal disease may consent to medical care related to the diagnosis or treatment of such disease. Ariz. Rev. Stat. Ann. § 44-132.01 (1971 Cum. Supp.)

Also, a female minor 12 or older alleged to be a rape victim may consent to medical and surgical care in connection with the rape when it is not possible to contact the parents or legal guardian within the short time span in which the examination should

be conducted. Ariz. Rev. Stat. Ann. § 44-135 (1971 Cum. Supp.)

We have found no cases indicating whether Arizona courts would accept the "mature minor doctrine" discussed in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

Under Arizona law it is a crime for a parent to "wilfully omit, without lawful excuse, to furnish necessary food, clothing, shelter or medical attention for his or her minor child. . . ." Ariz. Rev. Stat. Ann. § 13-801 (1956). It is also a crime for a person having custody of a minor under 16 to wilfully cause or permit "the life of such minor to be endangered, its health to be injured or its moral welfare to be imperiled, by neglect, abuse or immoral associations." Ariz. Rev. Stat. Ann. § 13-842 (1971 Cum. Supp.)

A "dependent child" is one who is adjudicated to be "destitute or who is not provided with the necessities of life." Ariz. Rev. Stat. Ann. § 8-201 (10) (b) (1971 Cum. Supp.). The juvenile court has jurisdiction over such children adjudicated as "dependent." "When a child under the jurisdiction of the juvenile court appears to be in need of medical or surgical care, the juvenile court may order the parent, guardian or custodian to provide treatment for the child in a hospital or otherwise." Ariz. Rev. Stat. Ann. § 8-245 (1971 Cum. Supp.). The parent of a "dependent child" may have his or her right to care, custody and control temporarily or permanently terminated by the juvenile court. *Anguis v. Superior Court In and For Maricopa County*, 6 Ariz. App. 68, 429 P. 2d 702 (1967). See also Ariz. Rev. Stat. § 8-241 (1971 Cum. Supp.)

Footnotes:

1. However, a female younger than 16 who is or is about to become a mother may, with parental consent and court approval, marry the father of her child; and a female who is or is about to become a mother may marry the father of her child even though he is under 18 provided he has parental consent and court approval. Ariz. Rev. Stat. Ann. § 25-102 (1956).
2. Marriage license applicants must have a medical examination including a blood test for syphilis. "Any person who by law is validly able to obtain a marriage license in the State of Arizona is validly able to give consent to any examinations and tests required by this article." Ariz. Rev. Stat. Ann. § 25-103.1 (1971 Cum. Supp.).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Arizona has a statute which provides for the compulsory sterilization of certain inmates of State hospitals. This statute contains the following provision:

Nothing in this article shall be construed to prevent medical or surgical treatment based on sound therapeutic rea-

sons of any person in the state by a physician or surgeon licensed by the state, which may incidentally involve nullification or destruction of reproductive functions. Ariz. Rev. Stat. § 36-540 (1966).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed on a person who is otherwise subject to the provisions of the compulsory sterilization law (i.e., a mental defective), the procedure prescribed in the sterilization law need not be followed although the operation may result in sterilization of the patient.

There is also a written state health department policy that voluntary sterilization should be made available. (See Health Policy section, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Arizona State Department of Health policy on family planning consists of a one page statement approved by the State Board of Health on January 15, 1971. The statement emphasizes a relationship between population growth and public health: "An increase in unwanted population (sic) threatens the health and well-being of many of our citizens." The statement also emphasizes the positive relationship between child spacing and family size limitation and family health. In the statement, the State Department of Health recommends "studies to determine the relationship of population growth to existing health conditions . . ." The integration of family planning into local health department programs, the adoption by state and local health departments of "the principle of the two-child family," and the promotion of "a zero population growth by encouraging and aiding families to limit their reproduction to two children." Freedom of choice as to method of contraception and freedom from coercion or compulsion regarding the adoption of family planning methods are supported by the statement; the role of family physicians in family planning services is emphasized. The policy maintains that voluntary sterilization for men and women should be made available in addition to contraceptive care.

2. *Eligibility:* The State Department of Health reported in the CFPPD survey that it recommends to local health agencies that all adults and all minors be considered eligible for family planning services except that those minors who are unmarried or not emancipated require parental consent. (See discussion of Contraception Law, Minors, above).

The Department "recommends in consultation to [sic] local health departments that no financial eligibility requirements of any kind be established for routine family planning services" in the written policy cited above. No geographical eligibility requirements or patient fees are indicated in the policy.

3. *Administration*:¹ The Maternal and Child Health Division has administrative responsibility for family planning services in the State Department of Health. The following professional staff are assigned to family planning activities: one medical director, 25–50 percent time; one public health nurse, 25–50 percent time; one school nurse consultant, 10–25 percent time; one clerk typist, 10–25 percent time. The Division performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services and of education and counseling activities.

4. *Financing*:² All \$70,444 of new MCH funds allocated to the State Department of Health in FY 1971 which were federally earmarked for family planning were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds in FY 1971 was \$363,990. An estimated \$27,300 of these funds were spent for family planning services. The Department had no specific appropriation for family planning from the state legislature for FY 1971. No other state funds were utilized by the Department for family planning services.

5. *Voluntary Sterilization*: The State Department of Health policy on voluntary sterilization is included in the family planning policy statement cited above. The policy states that voluntary sterilization services for men and women should be discussed and made available.

Footnotes:

1. Information in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Arizona welfare family planning policy is contained in Chapter XIII, *Child Welfare Manual of the Department of Public Welfare*. Family planning is covered in Sections 4–1300 through 4–1307. The basic policy of these sections was issued in April, 1969, but a revised Section 4–1307, which covers payment rates and procedures, was issued in May, 1971. Section 4–1305 provides that "Since many family planning clinics offer social as well as medical services, an immediate referral may be the extent of service needed by the client. . . . Often discussion of the subject [family planning] will extend through several interviews before a client is ready to decide whether or not to

seek further help from a clinic or physician." According to Section 4–1300, the objectives of family planning services are as follows:

1. To assist clients in decision-making relating to family planning.
2. To aid in maintaining and improving family health, particularly that of mothers and infants.
3. To improve the emotional and financial security of the family.
4. To strengthen marital and family bonds.
5. To enable clients to engage in rehabilitative training programs and in employment.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to purchase medical services for these recipients. According to Section 4–1306, "Clients may apply at any county welfare department or directly to a participating clinic or physician to receive medical family planning services."

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. The Department reported in the CFPPD survey that there is a single, standard statewide reimbursement rate for medical family planning procedures.² The reimbursement rates are as follows:

- Initial medical examination—not separately reimbursed.
- Annual medical examination—\$30.00.
- IUD insertion—\$30.00.
- One cycle of oral contraceptives—\$4.00.
- Use of medication or consumable supplies—\$4.00 per month.
- Any method not involving medication or consumable supplies—\$30.00 per year.

In addition, Section 4–1307 of the policy reads as follows:

The various methods of birth control offered by the clinics and physicians fall into two general groups for purposes of payment.

1. The first group involves periodic visits to clinic or physician for medication or consumable supplies.
 - A. The Department will pay clinics and physicians at the rate of \$4.00 per month for each client in this group.
 - B. To each client in this group, the Department will mail a new authorization each time a bill is received from a doctor or clinic. The client will turn in the authorization to the clinic or physician, who will return the signed card to the Department.
2. The second group involves one or more visits over a period of a year to clinic or physician for methods not involving medication or consumable supplies.
 - A. The Department will pay clinics and physicians at the rate of \$30 per year for each client in this group.
 1. The fee of \$30 covers the initial visit and follow-up visits during the remainder of the year.
 2. Payment will be made immediately after the initial visit and, for subsequent years, after the

first visit in each year, authorized from clinic or physician.

- B. To each client in this group, the Department will mail an authorization for only the first visit in each year. A new authorization will be mailed at the beginning of each subsequent year.

The Department has no contracts and/or other formal arrangement with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally aided assistance are eligible for medical family planning services under the policy. Applicants, past recipients, potential recipients of such assistance, and, according to the CFPPD survey, residents of low-income areas "are eligible only for counseling or referral on request." In Section 4-1305 the policy provides that "in the intact family, both husband and wife must be included in counseling." There are no other limitations that affect the provision of services to adults. Parental consent is required for the provision of services to all minors except those that are married or emancipated (See discussion, Laws Relating to Contraceptive Services to Minors, above). According to Section 4-1305, "an unmarried minor living with parents or relatives must be counselled through the parent or guardian rather than directly." The Department reported in the CFPPD survey that "Parental consent may be required by medical resource in case of unemancipated minors."

4. *Administration:*⁴ Responsibility for the admin-

istration of the family planning program is located in the Family and Child Welfare Services Division of the Department of Welfare. This Division has one consultant who spends from 10 to 25 percent of his time on family planning activities. Family planning activities of the Division include the training of local welfare staff and assistance in training clinic outreach workers, community and clinic liaison, and representation on the State Family Planning Advisory Committee.

5. *Financing:*⁵ There is a specific state appropriation for family planning in the Arizona Department of Public Welfare. In the state's last fiscal year, which ended June 30, 1971, there was an appropriation of \$35,000 to the Department of Welfare for family planning services.

6. *Voluntary Sterilization:* The Department of Public Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Information used in this section was reported by the state welfare agency in the CFPPD survey.
2. Arizona has not established a Medicaid program. The 1970 CUNY study reported that \$14,913 in state funds was expended for medical family planning services by Arizona under Title IV-A of the Social Security Act in fiscal year 1969. Projected expenditures under Title IV-A were \$25,000 for fiscal year 1970.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Arkansas

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Arkansas.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Arkansas has a law (*Arkansas Prophylactic Act*) which regulates contraceptives, defined as drugs or appliances for the prevention of conception or venereal disease. Ark. Stat. Ann. §§ 82-944 to 82-954 (1947). Under this statute a license is required to display, sell or otherwise dispose of contraceptives. An exception in the statute provides that it does not apply to physicians and medical practitioners licensed in Arkansas.

Two kinds of licenses may be issued:

(a) *Wholesale*—to wholesale druggists, drug sundries jobbers, surgical supply houses or manufacturers of contraceptive appliances and drugs;

(b) *Retail*—to retail drug stores employing one or more registered pharmacists.

One license is required for each place of sale; sales are authorized only to those holding licenses under this act. Retail sales must be made on the premises of the licensee and under the supervision of a registered pharmacist.

Sale of contraceptives by vending machine or by house to house or street solicitation is prohibited.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* The statute regulating contraceptives mentioned above prohibits advertising or display or exposure for sale of drugs or appliances for the prevention of conception. An exception is made for advertisements in medical and drug publications and for literature enclosed in or around the original package. § 82-950.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21 for males and 18 for females. Ark. Stat. Ann. § 57-103 (1948). There is a judicial procedure available whereby males of 18 or older and females of 16 or older may have the disabilities of minority removed. Ark. Stat. Ann. § 34-2001 (1971 Cum. Supp.).

A minor who is or believes himself or herself to be afflicted with venereal disease can consent to medical or surgical care or services. Ark. Stat. Ann. § 82-630 (1971 Cum. Supp.). The physician may but is not obligated to inform the spouse, parent or

guardian of such minor as to treatment given or needed. Such information may be given or withheld over the express objection of the minor. Ark. Stat. Ann. § 82-631 (1971 Cum. Supp.).

A law was passed in 1971 authorizing 18-year-olds to donate blood without parental consent; at that time, the legislature declared that the predecessor statute, which required minors younger than 21 to get parental consent in order to donate blood, was "not in accordance with the trend to give young adults greater authority and responsibility." Ark. S.B. 156, Act 44, 1971.

No Arkansas precedents were found for the general pattern of permitting medical treatment for minors without parental consent in emergencies and where the minors are "emancipated"; nor were any cases found upholding the "mature minor doctrine" referred to in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

It has been held, however, that whenever the parent in authority permits the child to contract for himself, "emancipation in respect of earnings may be implied." *Bonner v. Surman*, 215 Arkansas 301, 304, 220 S.W. 2d 431 (1949). And although no cases directly supporting the mature minor doctrine were found, a statement by the Supreme Court of Arkansas noted that "... a contract made for attorney's fees between an attorney and an infant, who is sufficiently intelligent to understand the nature and extent of the contract, is as binding as one for the necessities of life." *Midland Valley RR. Co. v. Johnson*, 140 Ark. 174, 181, 215 S.W. 665 (1919).

The Arkansas Supreme Court has held that children may be taken away from their parents and placed in a guardian's custody so that they may be vaccinated. *Cude v. State of Arkansas*, 237 Ark. 927, 377 S.W. 2d 816 (1964); *Mannis v. State of Arkansas*, 240 Ark. 42, 398 S.W. 2d 206 (1966), *cert. denied*, 384 U.S. 972.

The Health Department provides family planning services to married and emancipated minors and to those with one or more children without parental consent. A recent revision of the *Family Planning Manual* states a less restrictive policy. (See Health Policy section below).

B. Laws Relating to Voluntary Sterilization

Arkansas has a statute which provides for the ster-

ilization of certain mental incompetents. This statute contains the following provision:

Nothing contained in this Act shall be construed to limit or restrict the right of a competent adult to consent to a sterilization procedure on himself or to render liable any licensed hospital or its governing body (or members thereof) or its superintendent, administrators, agents, representatives, servants or employees nor any nurse or physician for the performance of a sterilization procedure upon a competent consenting adult. Ark. Rev. Stat. Ann. § 59-501 (m) (1971).

Thus voluntary sterilization for any reason is expressly permitted by statute in Arkansas.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Arkansas State Department of Health policy on family planning consists of a *Family Planning Manual* containing basic policies and procedures; the most recent revision of the *Manual* is dated December 1970. The *Manual* includes three basic parts: The first part contains, besides philosophy and purpose, general policies for family planning services relating to standards for the implementation of family planning programs, eligibility requirements for services, requirements for referral, admission policies for family planning services in health department clinics, follow-up services, record keeping, and reports. The second part is concerned with policies and procedures for clinic operations, for nursing procedures, for utilization of IUDs and oral contraceptives, for cytological screening and for specialized services. The third part consists of exhibits which detail various procedures.

2. *Eligibility:* The *Manual* states: "Any woman who desires the procedures offered and has no contraindications for their use is eligible [for family planning services], except in the case of a single college or university student away from home or in a residential school. . . . This patient is to be referred to her private physician for the initial care The local health department may accept a written order from a physician for follow-up care on these students. . . ." The *Manual* also states that in order to be eligible for the IUD type of family planning service [the patient] must have had at least one child (living or dead) prior to receipt of this service at a Health Department Clinic.

The State Department of Health reported in the CFPPD survey that it recommends that all categories of adults be considered eligible for family planning services and that married minors, emancipated minors, and minors with one or more children be considered eligible without parental consent. Unmarried and unemancipated minors, however, including those who have been previously pregnant but do

not have any children, require parental consent under the policy. The latter reported policy on minors appears to be somewhat more restrictive than that contained in the *Manual*.

3. *Administration:*¹ The Maternal and Child Health Division has administrative responsibility for family planning services in the State Department of Health. Professional staff assigned to family planning activities on the central staff of the Division include: three physicians, 25-50 percent time; two nurses, full-time; one nutritionist, full-time; one social worker, full-time; and several part-time clerks. The Division also reports field assignments for 187 public health nurses, 10-25 percent time and 116 clerks, 10-25 percent time. The Division performs the following functions in support of family planning activities: consultation; training, development and distribution of public educational materials; purchase of supplies, equipment or other materials for local family planning programs; general supervision of local programs; data collection and staffing of local programs.

4. *Financing:*² The State Department of Health received \$117,345 of new MCH funds for FY 1971 which were federally earmarked for family planning services. No information is available concerning the obligation of these funds. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$577,258. An estimated \$294,493 were spent for family planning services from this allocation. The Department did not receive a specific appropriation for family planning from the state legislature for FY 1971. No other state funds were utilized by the Department for family planning.

5. *Voluntary Sterilization:* The state health agency has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey; figures on allocations of MCH formula grant funds to state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Arkansas is contained in Sections 4440 and 4450 of the *Department of Public Welfare Manual* dated January 20, 1970. Additional family planning policy is found in Section 3.7 of the Title IV-A State Plan of Service Programs for Families and Children, dated July 1969. Section 4450 states that "family planning responsibilities include:

A. Dissemination of printed material to appropriate clients; B. Group discussions and individual discussions as indicated for women who have repeated births out-of-wedlock, those with first out-of-wedlock pregnancy or first out-of-wedlock child, those who are mentally retarded or those who have serious health problems." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to refer *eligible* public assistance recipients to medical family planning resources. Section 4450 states that the Department "does not operate family planning clinics; therefore, referral must be made to Health Department, OEO, and medical facilities operating such clinics." The Department *does not* reimburse providers of services for the provision of family planning services.² The Department has no contracts and/or other formal arrangements with providers of service for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as applicants, past recipients and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. General Assistance recipients are also eligible for referral services. There are no additional limitations that affect the provision of services to adults. Section 4450 of the policy states that "in respect to young persons under age, voluntary consent includes parental consent." It may be assumed

that "age" in this context means age of legal majority (18 for females, 21 for males except that a court procedure is available whereby males at 18 and females at 16 may have disabilities of minority removed—See Laws Relating to Contraceptive Services to Minors above).

4. *Administration:*⁴ It is not clear which subdivision of the Welfare Department has administrative responsibility for the welfare family planning program.

5. *Financing:*⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Public Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Arkansas Medicaid program, family planning services are "Not Provided." However, this publication is based on data as of January 1970 and the Arkansas Medicaid program may have been modified since that date. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

California

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* In 1965 the California legislature passed Concurrent Resolution No. 47 (Weingand Resolution) Cal. Stat. Ch. 222, 5421 (1965), encouraging public health departments to include family planning services in their programs.

In 1970 the legislature enacted several statutes relating to family planning. One directed the county health officer to prepare a list of family planning and birth control clinics located in his county for distribution by the county clerk, Cal. Health and Safety Code § 463 (1971 Supp.); another directed the county clerk to distribute to persons applying for a marriage license a list of family planning and birth control clinics located in that county. Cal. Gov't Code § 26808 (1971 Supp.)

There is, in addition, a statute permitting the State Department of Health to include among its activities collection and analysis of data on demographic and population matters including fertility, abortion and other factors related to population dynamics. The department may assess the health, environmental and related effects of current and projected population trends and formulate recommendations to respond to the projected trends. Cal. Health and Safety Code § 429.50 (1971 Supp.).

A 1971 amendment to the Welfare and Institutions Code provides that family planning information and referral services are to be made available for all persons. Cal. Welf. & Inst'n's Code § 10053.2 (1971 Supp.).

The amendment also states that family planning services shall be offered and provided to all "former, current or potential [public assistance] recipients of childbearing age, age 15 to 44, inclusive" without regard to marital status, age or parenthood. "Potential recipients" is defined in the statute as "all persons in a family where current social, economic and health conditions of the family indicate that the family would likely become a recipient of financial assistance within the next five years." Family planning services are to include medical contraceptive services, supplies and facilitating services (transportation, child care) and informational and educational services. Cal. Welf. & Inst'n's Code § 10053.2 (1971 Supp.). Family planning services under this amendment are to be "provided by contracts be-

tween the county Welfare Department and the State Department of Public Health." The statute requires that these contracts include to the maximum extent possible, cooperative funding and other financial arrangements which permit maximum use of available federal funds. Section 10053.3 requires the county Welfare Department to submit a quarterly statistical report on the operation of § 10053.2 to document the effectiveness of the program.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

California does have a statute regulating prophylactics, enacted in 1955. Cal. Bus. and Prof. Code §§ 4301 to 4325 (1970). The statute defines prophylactics as devices or medicinal agents used in the prevention of venereal disease, and prescribes regulations for the dispensing, displaying, advertising, labelling, quality and standards of prophylactics. An exemption from the provisions of the law is made for physicians disposing of prophylactics within the regular practice of their profession. The statute provides for two kinds of licenses, wholesale and retail. Retail licenses are to be issued only to licensed pharmacies and to persons holding general dealers' permits issued under the statute. Licensed wholesalers may sell prophylactics only to other licensees or to physicians. Manufacturers who have wholesale licenses may sell only to wholesale or retail licensees under this law. Licensed retailers may sell to other licensees, to physicians or to any other person under the conditions specified in the act. (This section was recently amended to permit sale to "any other person": previous restrictions permitted sale only to married persons or persons over 18). A licensed retailer may sell prophylactics only in the place of business for which his license has been granted. He may dispense any device or appliance pursuant to a prescription even if the manufacturer is not identified thereon. The use of vending machines to sell or dispose of prophylactics is prohibited under the statute.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* A statute making it a felony to advertise any medicine or means for procuring abortion or for the prevention of conception (Cal. Bus. and Prof. Code § 601.) was amended in 1971 so as to delete reference to conception entirely. Thus,

advertising contraceptives and information about contraception is now legal in California. Section 4322 of California's Prophylactics Act was also amended in 1971 so as to permit public advertisement or display of prophylactic products if such advertisements or displays are accompanied with educational information on venereal disease prevention. Cal. Bus. and Prof. Code § 4322 (1971). Another recent amendment of this section permitted licensed pharmacists, physicians and public health officers to disseminate information on the availability and use of prophylactics in the prevention of venereal disease. Section 4322 also permits publication and distribution of professional literature through professional channels of information.

4. Laws Relating to Contraceptive Services to Minors: Minors are all persons under 21 years of age, except that any person who is 18 or older and married may enter into any contract. Cal. Civ. Code § 25 (West Supp. 1971).

Age of Consent to Medical Care in General: While as a general rule, parental consent had been required for the provision of services to minors,¹ California has "a consistent series of enactments designed to free particular classes of minors from the necessity of obtaining parental consent to various medical services. In each section the Legislature recognized the interest of the minors in availing themselves of various medical services without parental consent and the interest of the community in permitting the ready availability of medical aid." *Ballard v. Anderson*, 4 Cal. 3d 873, 882 (1971).

Section 25.6 of the Civil Code enables all married minors to consent to medical and surgical care. Cal. Civ. Code § 25.6 (West Supp. 1971). The fact that the marriage is later dissolved does not deprive such person of his adult status once attained.

Section 25.7 permits minors on active duty in the armed services to consent to medical and surgical care. Cal. Civ. Code § 25.7 (West Supp. 1971).

Section 34.5 enables an unmarried, pregnant minor to consent to medical and surgical care related to her pregnancy. Cal. Civ. Code § 34.5 (West 1954).² This has been held to include therapeutic abortion. *Ballard v. Anderson*, *supra*. The California Supreme Court said that it does not include medical care aimed at preventing pregnancy "because such care is administered before any pregnancy exists and for the purpose of avoiding the condition of pregnancy." (However, under the Welfare Reform Act of 1971, discussed below, family planning services are provided to all former, current and potential public assistance recipients who wish such services, age 15 to 44, regardless of marital status, without parental consent.)

Section 34.6 provides that a minor 15 years of age or older who is living separate and apart from his

parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing his own financial affairs, regardless of the source of his income, may consent to medical or surgical care. Cal. Civ. Code § 34.6 (West Supp. 1971).³

The consent of the parents or legal guardian shall not be necessary and such parents or legal guardian shall not be liable for any care rendered pursuant to section 34.6. The physician may, however, with or without the consent of the minor patient, advise the parents or legal guardian of the treatment given or needed if the physician has reason to know, on the basis of the information given him by the minor, the whereabouts of the parents or legal guardian. *Ibid*.

Section 34.7 of the Civil Code provides that a minor 12 years of age or older who may have come into contact with any infectious or communicable disease may consent to medical and surgical care related to the diagnosis or treatment of such disease, if the disease or condition is one which is required to be reported to the local health officer. The consent of the parents or legal guardian shall not be necessary and such parents or legal guardian shall not be liable for payment for any care rendered pursuant to this section. Cal. Civ. Code § 34.7 (West Supp. 1971).

Age of Consent to Contraceptive Services: The Welfare Reform Act of 1971 includes an amendment to the Welfare and Institutions Code which provides that family planning services shall be *offered* to all former, current or potential public assistance recipients of childbearing age (defined in the statute as age 15 to 44, inclusive) without regard to marital status, age or parenthood, and *provided* to those former, current or potential recipients wishing such services. Cal. Welf. and Inst'n's Code § 10053.2 (1971).

The statute specifically provides that, notwithstanding any other provisions of law, the furnishing of these family planning services shall *not require the consent* of anyone other than the person who is to receive them. "Services" are defined as including medical contraceptive service such as diagnosis, treatment and supplies as well as informational services.

"Potential recipients" are defined in the statute as "all persons in a family where current social, economic and health conditions of the family indicate that the family would likely become a recipient of financial assistance within the next five years."

The statute provides that information and referral services only shall be available to families and children other than those who are former, current or potential recipients of public assistance.

Section 14010 of the *Welfare and Institutions Code*, also added by the Welfare Reform Act of 1971, provides that the parent or parents of a child under 21 shall not be held financially responsible for health care or related services to which the child may consent without the need for parental consent under any express provision of law.

In December, 1971, Governor Reagan vetoed Senate Bill 375, passed by both houses of the Legislature, which would have allowed all minors to receive contraceptive services without parental consent.

A statutory prohibition of sales of prophylactics to persons under 18 was repealed in 1970. Cal. Bus. and Prof. Code § 4319 (West Supp. 1971).

Court Decisions Respecting Medical Treatment of Minors. A California Supreme Court opinion contains a *dictum* to the effect that, in case of an emergency, a surgeon may operate on a minor child without waiting for authority from the parents. See *Farber v. Olkon*, 254 P. 2d 520, 524 (Sup. Ct. Cal. 1953). It has been held that a surgeon confronted with an emergency may operate on an anesthetized (adult) patient without the patient's express consent. *Wheeler v. Barker*, 92 Cal. 2d 776, 208 P. 2d 68 (Dist. Ct. of App. 1949).

Since there are no reported cases on the subject, it is not clear whether California courts would accept the "mature minor doctrine" referred to in the Summary and Analysis of State laws Relating to Contraceptive Services to Minors.

Other Legislative Provisions: California has a statute allowing the juvenile court to authorize medical and surgical care for a neglected child upon the written recommendation of a qualified physician when there is no parent, guardian or person standing in loco parentis capable of authorizing or willing to authorize such care. Due notice must be given to the parent, guardian, or person standing in loco parentis, unless the minor requires immediate emergency care. The statute provides that nothing therein shall be construed as limiting the right of a parent, guardian or person standing in loco parentis, who has not been deprived of the custody or control of the minor by order of the court, in providing any medical or surgical treatment recognized or permitted under the laws of the state. Cal. Welf. & Inst'ns Code § 739 (West Cum. Supp. 1971).

In 1969, California enacted certain prohibitions against sex education in California public schools. Cal. Educ. Code § 8506 (West Cum. Supp. 1971). Among other things, this law provides that, with certain exceptions, "no governing board of a public elementary or secondary school may require pupils to attend any class in which human reproductive organs and their functions and processes are described, illustrated or discussed . . ." In addition, the

parent or guardian of each pupil enrolled in such class must be notified in writing and given the opportunity to request that his child not attend the class.⁴

Footnotes:

1. See *Ballard v. Anderson*, 4 Cal. 3d 873 (1971; *Farber v. Olkon*, 254 P. 2d 520, 524 (Sup. Ct. Cal. 1953); *Buckner v. Vetterick*, 269 P. 2d 67, 69 (Cal. Dist. Ct. of App. 1954); Cal. Civ. Code § 25.8 (West. Supp. 1971); Opin. of Atty. Gen. NS 5116 (Sept. 21, 1943).
2. A 1971 statute enables an unmarried minor mother of a child who is under the jurisdiction of the Juvenile Court to authorize medical and surgical care for the child. Cal. Welf. & Inst'ns Code § 739 (g) (1971).
3. California has recognized for other purposes that a minor living at home but working and contributing to the family finances may be emancipated. See *Martinez v. Southern Pacific Co.*, 288 P. 2d 868 (Sup. Ct. Cal. 1955).
4. There is an Attorney General's opinion to the effect that this law does not apply to California Junior Colleges. Atty. Gen. Opin. No. 69-275 (Jan. 29, 1970).

B. Laws Relating to Voluntary Sterilization

Case law provides that "voluntary nontherapeutic surgical sterilization operations are legal in the State of California." *Jessin v. County of Shasta*, 274 Cal. App. 2d 737, 749, 79 Cal. Reprtr. 359 (Ct. App. 3d D. 1969).

The *Jessin* case involved an appeal from a judgment declaring voluntary nontherapeutic surgical sterilization to be legal in the State of California and authorizing the defendant County of Shasta to perform such operations upon willing qualified medical indigents, such as the plaintiffs. The plaintiffs, husband and wife, alleged that they were unable to provide medical care and health services for themselves and were eligible to receive such services from the appropriate county public health agency. They contended that as they were already the parents of as many minor children as they could adequately care for and support, the county was required by law to furnish them with surgical sterilizations. The county refused to provide the services on the stated belief that the rendering of such services would be unlawful. After a short trial, the trial court held as follows:

It is adjudged that voluntary nontherapeutic surgical sterilization operations are legal in the State of California; that voluntary nontherapeutic surgical sterilization operations when requested are health needs of the poor within the meaning of Section 1445 of the Health and Safety Code of the State of California; that voluntary nontherapeutic surgical sterilization operations when requested are basic and appropriate services in the field of family planning within the meaning of Section 1276 of the Administrative Code of the State of California; that it is the duty of Shasta County to perform such operations when requested by persons entitled to receive the public health services of Shasta County.

The Court of Appeal affirmed the judgment of the trial court, but modified it by deleting everything which followed the language: "IT IS ADJUDGED that voluntary nontherapeutic surgical sterilization operations are legal in the State of California."¹

In its opinion, the California Court of Appeal stated:

California has no public policy prohibiting consensual sterilization operations, and . . . nontherapeutic surgical operations are legal in this state where competent consent has been given.

An earlier case, *Custodio v. Bauer*, 251 Cal. App. 2d 303, 59 Calif. Reprtr. 463 (Ct. App. 1st D. 1967), was an action for damages resulting from the pregnancy of Mrs. Berdella Custodio following the failure of an operation undertaken and performed to sterilize her for medical reasons. The court rejected the argument that the operation was against public policy, and held that, if the plaintiffs Mr. and Mrs. Custodio could show negligence or breach of warranty, they would be entitled to recover damages for physical and mental suffering resulting from the unwanted pregnancy as well as for any other "foreseeable consequences of the failure of the operation." These damages would include compensation for the mother's death or injury to her health caused by the delivery, and even if she were to survive "without casualty" they would also compensate the family for the loss caused because the mother must spread her care and support over a larger group. The court did not rule on the question of whether damages could be recovered for the cost of rearing the unwanted child.

Recent California statutes are consistent with the holding in *Jessin v. County of Shasta* above. These statutes invalidate provisions in various types of insurance policies covering sterilization operations or procedures which contain any exclusion, restriction or limitation based upon the insured's reason for requesting sterilization. The statutes apply to disability insurance (Calif. Ins. Code § 10120 (Supp. 1971); self-insured employee welfare benefit plans (Calif. Ins. Code 10121, Supp. 1971); family hospital service contracts (Calif. Inc. Code § 11512.1, Supp. 1971) and health care service plans (Calif. Gov't Code § 12532.7, Supp. 1971).

The *Jessin* decision has been followed by the Attorney General of California in an opinion that "nontherapeutic sterilization of prisoners is permissible with the informed consent of the prisoner." Opinion No. 70-100, November 5, 1970.

We have seen that under Section 10053.2 of the Welfare and Institutions Code, family planning services must be made available to all former, current or potential recipients of public assistance regardless of age, marital status or parenthood without regard to parental consent. (See Laws Establishing

Family Planning Programs, above.) It is not clear whether "family planning services" for this purpose includes voluntary sterilization. The *Jessin* case, discussed above, construed a different provision (Section 1276 of the Administrative Code, which is discussed under Health Policy, below.)

Footnote:

1. This language was deleted, not because the appellate court disagreed with it, but because it was not in controversy and the court ruled that no proper consideration was given to it in the trial.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* California State Department of Public Health policy on family planning has evolved since 1961 when the California Conference of Local Health Officers adopted a policy urging local health departments to take leadership in the development of family planning services "for those groups who cannot reasonably obtain them." In 1963 the administrator of the State Health and Welfare Agency established a policy stating that "more expansion of family planning services in California is needed." In 1966 the State Board of Public Health adopted a recommendation from the California Conference of Local Health Officers making it a requirement that local health departments provide family planning services and introduced this into the California State Administrative Code, Section No. 1276 of Title XVII. Section 1276 states that the health department shall offer to the health jurisdiction which it serves "appropriate services in the field of family planning . . ." which may include the development and dissemination of information about family planning and population, the provision of professional services for sterility correction and genetic counseling, the evaluation of community family planning efforts, and the "provision of program elements which are not otherwise likely to be made available, including family planning services for those groups who cannot reasonably obtain them."

In 1968 the Bureau of Maternal and Child Health published "Suggested Standards and Recommendations for Public Family Planning Services," which was developed as a guide to professional health workers in the family planning field.

2. *Eligibility:* The State Department of Public Health reported in the CFPPD survey that all financial, social and geographical eligibility requirements and patient fees are determined locally. According to informal communications from the Department's Bureau of Maternal and Child Health,¹ the policy on eligibility for family planning services is "to encourage local service agencies to accept patients regardless of the length of residency in the State, source of referral, or any other descriptive characteristics."

The policies and regulations of local service agencies, county governments, and private physicians are "respected . . . in general, it can be said that urban areas are the most liberal and that the rural areas have the more restrictive policies regarding eligibility. The main eligibility barrier remaining is that of the age of the potential patient, with respect to her status as a minor. However, in virtually every County, the provisions of the Emancipated Minor Act (A.B. No. 334) are being followed."

Apart from official, written policy, the Department indicated in the CFPPD survey that the following eligibility requirements are applicable in local health department programs: all adults are eligible for family planning; all minors are eligible *with* parental consent except that parental consent is not required for married or emancipated minors. The minimum age for services to unmarried minors is 15.

Fees cannot be charged recipients by agencies which receive MCH funds, according to the informal communications cited above, although the Bureau of Maternal and Child Health encourages reimbursement from third parties where applicable.

3. *Administration:*² The Bureau of Maternal and Child Health has administrative responsibility for family planning services in the State Department of Public Health. Professional staff are assigned to family planning activities as follows: Chief, Bureau of Maternal and Child Health, less than 10 percent time; one maternal health and family planning physician, full-time; one maternal nursing consultant, full-time; one maternal nursing consultant, 25 to 50 percent time; other professionals (10), less than 10 percent time; clerical staff (3), full-time. The Bureau performs the following functions in support of family planning activities: consultation, training, development and distribution of public educational materials, and grants or contracts to local family planning programs.

4. *Financing:*³ The Department was allocated \$488,349 of new MCH funds for FY 1971 which were federally earmarked for family planning. \$356,745, or 73 percent, of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$2,339,805. An estimated \$324,214 of these funds were spent for family planning services. The state health agency received a \$1 million appropriation for family planning services for FY 1972 from the state legislature. These funds are to be used to match federal funds available through Title IV-A of the Social Security Act. (See Welfare Policy, below). No other state funds are utilized by the state health agency for family planning services.

5. *Voluntary Sterilization:* The state health agency has no written policy in regard to voluntary sterilization.

Footnotes:

1. Letter from the Chief, Bureau of Maternal and Child Health to the Region IX Program Management Officer, National Center for Family Planning Services, DHEW, December 31, 1970.
2. Information contained in this section was reported by the state health agency in the CFPPD survey.
3. Figures on allocations of MCH formula grant funds to state health agencies are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in California is contained in Chapter 30-450 of the *Public Social Service Manual*, dated January 1, 1970. The Department of Social Welfare is preparing additional policy material designed to implement Section 10053.2 of the Welfare and Institutions Code enacted during the 1971 legislative session. According to Section 30-451:

The broadest array possible of family planning services shall be made available to individuals to meet one or more of the following objectives:

- 21 To promote the health of mothers and children.
- 22 To provide parents and potential parents the opportunity to determine the timing, number and spacing of their children.
- 23 To reduce the incidence of maternal mortality and morbidity.
- 24 To reduce the incidence of infant mortality and morbidity; including prematurity, mental retardation, and congenital defects.
- 25 To strengthen family life, including preventing or reducing the incidence of births out-of-wedlock.

Section 30-455 states that "Each person for whom family planning services are appropriate and who is eligible for services, shall be offered information and assistance with respect to such Services."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients. In addition, child care and transportation is provided when necessary to enable eligible recipients to attend clinics.

Effective January 3, 1972, health department and voluntary agencies will be authorized to receive payment for family planning services provided to eligible individuals. The Department reported that it is currently negotiating an interagency agreement with the State Department of Public Health "which will authorize payment to local public family planning clinics and voluntary family planning clinics for services rendered to current, former and potential recipients." There is no single, standard, statewide reimbursement rate for medical family plan-

ning procedures except for a state-wide fee of \$6 for a Pap Smear.²

3. *Eligibility:*³ All current recipients of federally-aided assistance, as well as past and potential recipients of such assistance are eligible for medical family planning services. Applicants for such assistance are eligible for information and referral services only. Residents of low-income areas and General Assistance recipients are not eligible for either medical or information and referral services.

There are no additional limitations that affect the provision of services to adults or minors. Section 10053.2 of the Welfare and Institutions Code provides that family planning services shall be offered to all eligible persons between the ages of 15 and 44. Subsection 30-453 of the Manual states that "services shall be offered and made available to any parent or potential parent eligible for public social services who wishes such services."

4. *Administration:*⁴ Responsibility for the administration of the family planning program rests with the Family Services Bureau. One Social Service Consultant in the Bureau devotes full-time to family planning activities. The Bureau provides training for local Welfare staff, develops and distributes educational materials, and is responsible for liaison with the State Department of Public Health and the California Interagency Council on Family Planning.

5. *Financing:*⁵ The Department reported that the California legislature has appropriated one million dollars to the Department of Public Health to finance a state-wide, health department-operated fam-

ily planning program "for current recipients and former and potential recipients of AFDC."⁶ Expenditure of these funds in fiscal year 1972 will be claimed "as the local match for Title IV-A funds." This means that the State will receive three federal dollars for each state dollar expended for family planning services under this program.

6. *Voluntary Sterilization:* The Department of Social Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local welfare agencies. Local welfare agencies, however, are not authorized to pay for voluntary sterilization procedures.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the California Medicaid program family planning services are "provided, but not as a separately identified service. Drugs, supplies, and appliances are included." The 1969 City University of New York study reported that \$1,150,000 was expended for contraceptive drugs and devices by the California Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures for drugs and devices were \$1,419,000. (For additional information on Medicaid, see Federal Laws and Policy section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. AFDC: Aid to Families with Dependent Children, Title IV-A of the Social Security Act.
6. As reported in CFPPD survey.

Colorado

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* In 1971, the Colorado legislature enacted a new Family Planning statute establishing the policy of the state on the subject of contraception. Colo. Rev. Stat. Ann. §§ 66-32-1 to 66-32-3 (1971 Supp.). The statute directs that "all medically acceptable contraceptive procedures, supplies and information . . . be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship or motive." The statute specifies that contraceptive procedures, including sterilization, are consistent with public policy, as is dissemination of contraceptive information by authorized persons at schools, in state and county health and welfare departments, in medical facilities at institutions of higher learning, and at other agencies and instrumentalities of the state. Hospitals, clinics, medical centers, institutions or pharmacies may not subject any person "to any standard or requirement as a prerequisite for any contraceptive procedures, supplies or information including sterilization, other than referral to a physician." A physician may refuse to furnish contraceptive supplies or information for medical reasons. Physicians and private institutions and their employees may also refuse to provide such information and supplies for reasons of religion or conscientious objection. To the extent that family planning funds are available, the statute directs each agency and institution of the state to provide contraceptive procedures, supplies and information to indigent persons free of charge and to others at cost. The Department of Health is also authorized to receive and disburse funds for family planning programs to public or private organizations engaged in providing contraceptive supplies and information. Any family planning program administered by the Department of Health is to be developed in consultation and coordination with other family planning agencies in the state, including but not limited to the Department of Social Services. This 1971 legislation, though establishing state policy, is limited in functioning to the extent that funds are available.

The statute supplements another statute authorizing each county and city, or the health or welfare department of such county and city, to provide, pay

for, and offer family planning and birth control services to every parent who is a public assistance recipient and to any other interested parent or married person who would benefit from same. Colo. Rev. Stat. Ann. §§ 36-20-1 to 36-20-7 (1963). These services are to include interviews, distribution of literature, referrals to physicians for consultation, examination, tests, medical treatment and prescriptions, and to the extent so prescribed, the distribution of rhythm charts, drugs, medicinal preparations, contraceptive devices and similar products. The governmental unit providing these family planning services may charge the persons receiving the services for all or a portion of the costs of services rendered. Any person may refuse to accept family planning and birth control services and this will not affect his or her right to receive public assistance or other public benefits. These family planning services shall not be given unless the interviews and literature are in a language which the potential recipient understands.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

Colorado's Prophylactics Act regulates the manufacture, sale or possession of prophylactics. Colo. Rev. Stat. Ann. §§ 66-10-3 to 66-10-12 (1963). Prophylactics are defined as devices or drugs for the prevention or treatment of venereal disease. They may be manufactured or sold only by licensees under the statute and in accordance with statutory provisions and standards. Physicians may sell or give prophylactics to their patients in the regular practice of their profession. There are two classes of licenses under the statute, a wholesaler's and a manufacturer's. A wholesaler's license entitles the licensee to sell or dispose of prophylactics to any licensed pharmacy; a manufacturer's license entitles the licensee to sell prophylactics to any licensee with a wholesaler's license. Vending machine sales are prohibited.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* The Prophylactics Act, above, also regulates the display and advertising of prophylactics. Prophylactics may be advertised only in professional publications whose circulation is limited to physicians or the drug trade. They may be

displayed only by licensees under the statute. Colo. Rev. Stat. Ann. § 66-10-4 (1963).

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 21. Colo. Rev. Stat. Ann. §§ 135-1-2; 153-1-1 (1964). However, as part of the Family Planning Act of 1971, Colorado adopted a statute authorizing birth control services for minors under which birth control procedures, supplies and information may be furnished by licensed physicians "to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of [the State of Colorado] or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information." (emphasis added) Colo. Rev. Stat. Ann. § 91-1-38 (added by 1971 Session Laws, chapter 161, S.B. No. 230).

In 1971, Colorado also adopted a comprehensive statute providing for medical care of minors. Colo. Rev. Stat. Ann. § 41-2-13 (added by 1971 Session Laws, Chapter 124, S.B. No. 169). Under the new law, "a minor eighteen years of age or older, or a minor fifteen years of age or older who is living separate and apart from his or her parent, parents, or legal guardian, with or without the consent of his or her parent, parents, or guardian, and is managing his or her own financial affairs, regardless of the source of his or her income, or any minor who has contracted a lawful marriage, may give consent to the furnishing of hospital, medical, dental, and surgical care to himself or herself."

The statute further provides that no hospital or physician "who, in good faith relies on such a minor's consent, shall be liable for civil damages for failure to secure the consent of such a minor's parent, parents, or legal guardian, prior to rendering such care." The parents or legal guardian are not liable for the charges for the care provided to the minor on his or her consent unless the parents or legal guardian agree to be held liable.

Colorado also has a statute authorizing any physician to diagnose and treat a minor for venereal disease without the consent of or notification to the parent or guardian of the minor. In any such case the physician is protected from civil or criminal liability except for negligence. Colo. Rev. Stat. Ann. § 66-9-2 (4) (1967 Supp.).

B. Laws Relating to Voluntary Sterilization

The 1971 Colorado statute discussed above under *Laws Establishing Family Planning Programs* provides that "contraceptive procedures, including medical procedures for permanent sterilization, when performed by a physician on a requesting and con-

senting patient, are consistent with public policy;" as stated above, that statute directs that all contraceptive procedures shall be made readily and practicably available to every person who wishes them.

This statute also provides that:

[n]o hospital, clinic, medical center, institution, or pharmacy shall subject any person to any standard or requirement as a prerequisite for any contraceptive procedure, supplies, or information, including sterilization, other than referral to a physician.

This statute provides that:

[n]o private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal. Colo. Rev. Stat. § 66-32-2 (1971).

These two provisions are not inconsistent. In Colorado, a hospital or physician may refuse to permit or perform voluntary sterilization for reasons of conscience. A hospital, however, although it may legally refuse to permit *all* voluntary sterilizations (or all voluntary sterilizations except for reasons of medical necessity), may not impose special requirements as prerequisites to voluntary sterilization such as an age parity formula or the like.

Minors: The above statute specifically provides that no unmarried person under 18 years of age may consent to permanent sterilization procedures without the consent of parent or guardian. Colo. Rev. Stat. Ann. § 66-32-2 (1971). Minors who are 18 or married do not require parental consent for any contraceptive procedure, including voluntary sterilization (See *Contraceptive Services to Minors*, above).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The Colorado Department of Health has no written family planning policy. In March 1971, the legislature approved the Family Planning Act of 1971 which expands the powers and duties of the Department of Health with respect to the initiation and administration of family planning programs. (See *Contraception Laws*, above). Prior to passage of this legislation, the State Health Department had power only to distribute federal and state family planning funds to local health department units for the development of family planning services (Letter from the Colorado Attorney General to the Executive Director, Colorado Department of Health, December 29, 1970).

2. *Eligibility*: The Department of Health reported in the CFPPD survey that financial and social eligibility policies and patient fees for family planning

services are recommended by the Department and determined by local health agencies. Although the state makes no requirements regarding financial eligibility, the health agency recommends the use of a "financial eligibility guide" from the state's handicapped children program, which is similar to the standards for Federal Crippled Children's Programs, as a guide to localities which choose to utilize it.

The Department recommends that all categories of adults and minors be considered eligible for family planning services. In the case of minors, no recommendations are made with respect to parental consent or minimum age. Geographical requirements for eligibility in state policy are established by the state MCH plan which limits the Department to serving residents of Colorado. Local residency requirements are determined by local health agencies. With respect to patient fees, the Department indicated in the CFPPD survey that where Public Health Service Act Title X funds are being used, the Department will recommend that services be provided free to families of four earning less than \$5,000 (with \$50 added to the ceiling for each additional child) and that charges be made on a sliding fee scale for patients with higher incomes.

It should be noted that the 1971 Act cited above mandates "each agency and institution of this state and each of its political subdivisions" to abide by the eligibility standards "recommended" by the state health agency. In contrast with the Department's recommended financial and geographical eligibility standards noted above, the 1971 statute directs that family planning services should be available to all persons desiring these regardless of sex, race, age, income, number of children, marital status, citizenship or motive (See Contraception Law, above).

3. Administration:¹ The Maternal and Child Health Section, Child Health Services Division, has administrative responsibility for family planning services in the Department of Health. Professional and clerical staff of the Child Health Services Division assigned to family planning include: the Division Director, 25 percent time; one public health educator, 25 percent time; one nutrition consultant, 15 percent time; the social work section chief, 33 percent time; one public health coordinator, 50 percent time; one school nursing consultant, 15 percent time; one program consultant, 75 percent time; one administrative assistant, 50 percent time; and one senior clerk steno, 100 percent time. The Division performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts

to local family planning programs for support of services.

4. Financing:² \$92,348 of new MCH funds were allocated to the Department of Health in FY 1971 which were federally earmarked for family planning. Of these funds, \$40,000 or 43 percent were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds was \$376,900. None of these funds were spent for family planning services. The Department received a \$46,667 appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Department for family planning services.

5. Voluntary Sterilization: The Department of Health appears to have no written policy on voluntary sterilization. The 1971 Family Planning Act referred to above contains specific provisions regarding voluntary sterilization (See Contraception and Voluntary Sterilization Law, above). Although the Act specifically authorizes and requires state and local health agencies to provide "permanent sterilization procedures," the Department reported in the CFPPD survey that it makes no provision for the purchase or provision of voluntary sterilization for males or females, although it does make provision for referrals for sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey; figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. Summary of Current Welfare Policy: Welfare family planning policy in Colorado is contained in Sections A-7410.22, A-7460, and C-7032 in Volume VII of the Division of Public Welfare Staff Manual. Section A-7410.22, dated January 1970 states that "social, educational and medical contraceptive services must be available and provided to those individuals desiring them without regard to marital status, age, or parenthood." The basic family planning policy is stated in Section A-7460, dated December 1968, which requires that "if family planning services are not provided by the county department itself, but such services are available without cost in another agency, the county department must be equally sure that such services are actually provided." The objectives of the family planning program as stated in Section A-7460 are "to promote and safeguard individual, family, and community health and well-being by making knowledge of scientific methods of family planning available in order that the spacing

of children and family size may be on the basis of such knowledge and within the control of the individual. Further, such services are especially designed to coordinate with casework services in the prevention or reduction of births out of wedlock."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical family planning services for these recipients.

The policy provides for reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. The reimbursement rates for various family planning procedures are based on "reasonable and customary" charges.² The Department reported having entered into contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services under the policy. Applicants, past recipients, potential recipients of such assistance, and residents of low-income areas are eligible only for information and referral services. General Assistance recipients are eligible only for information and referral services.

There are no additional limitations that affect the provision of services to adults or minors. However, according to section A-7460, "the first priority for such services shall be parents who have had children

born out-of-wedlock within the preceding two years, or when the woman is currently pregnant."

4. *Administration:*⁴ Responsibility for administration of the family planning program rests with the Family and Children's Service Section in the Division of Public Welfare. One Unmarried Parents Consultant spends less than 10 percent of her time on family planning services. Family planning activities of the Section include the training of local welfare staff and the development and distribution of public educational materials.

5. *Financing:*⁵ There is no specific state appropriation for family planning activities in the Department of Social Services.

6. *Voluntary Sterilization:* The Department of Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department authorizes *referral* for and the purchase of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971, states that family planning services are "Provided. Consisting of physicians' services, drugs, supplies, and devices. Physicians' services limited to medical visit(s) necessary to determine medications or devices to be used." The extent of utilization of the Medicaid program is unknown. (See Federal Law and Policy Section in this report.)

3. As reported in CFPPD survey.

4. Ibid.

5. Ibid.

Connecticut

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: There is no law establishing a state family planning program in Connecticut.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

Connecticut's old law making it a crime to use contraceptives, Conn. Gen. Stat. Rev. § 53-32,¹ was the subject of the Supreme Court's landmark decision in *Griswold v. Connecticut*, 381 U.S. 479 (1965), where the Court struck down § 53-32 as violative of the constitutionally protected right of "marital privacy." The *Griswold* case established the right of married persons to use contraceptives and the right of physicians and birth control clinics to provide contraceptive advice and assistance. It has since frequently been cited as declaring "a right of privacy in matters related to marriage, sex and the family."²

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: None found.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority has been reduced to 18. Public Act No. 127 (signed May 9, 1972). An earlier law provided that any minor of 18 or older could give effective consent to medical and health services. Public Act No. 304 (effective Oct. 1, 1971).

Before the age of majority was lowered to 18, Connecticut's law prohibited the issuance of a marriage license to persons under 21 without written parental consent,³ Conn. Gen. Stat. Ann. § 46-5g (1972 Cum Supp.); presumably this age limitation is now 18. However, the courts have held that the marriage of a minor is valid even without parental consent. *Manning v. Manning*, 16 Conn. Supp. 461 (1950); see also *Thompson v. Thompson*, 14 Conn. Supp. 511 (1947); *Gould v. Gould*, 78 Conn. 242 (1905) (dictum).

In *Town of Torrington v. Town of Norwich*,⁴ 21 Conn. 542 (1852), the court held that a minor son may be emancipated by marriage. In *Town of Milford v. Town of Greenwich*, 126 Conn. 340, 11 A. 2d 352 (1940), it was held that the marriage of a minor, at least with the consent of the parents, works an emancipation.

The Connecticut Attorney General, in an opinion issued before the reduction of the age of majority,

said that consent of parents to an operation on a minor was not required where the minor was 19 years old, married and the mother of two children. The Attorney General stated:

It seems to us that the fact that the patient is married and the mother of two children evidences a strong presumption that she has been emancipated from her parents. This fact, coupled with the fact that she is close to maturity, makes her, in our judgment, competent to consent for her surgical operation. . . . 29 Op. Atty. Gen. 18 (Feb. 16, 1955).

Though we have found no cases or Attorney General's opinions involving medical treatment of minors emancipated by means other than marriage, Connecticut courts do view emancipation as an extinguishment of parental rights and duties (see cases discussed below) and may be presumed to follow the general pattern of permitting an emancipated minor to consent to his or her own medical care without the necessity of parental consent.

Some examples of how the Connecticut courts view emancipation follow:

There is no presumption of emancipation at any age short of majority. *Shea v. Pettee*, 19 Conn. Super. 125, 110 A. 2d 492 (1954). Emancipation of an infant may relieve him of his obligation to his parents and may have other results but does not remove all the disabilities of infancy. *Altieri v. Altieri*, 21 Conn. Super. 376, 155 A. 2d 758 (1959).

In *Wood v. Wood*, 135 Conn. 280, 63 A. 2d 586 (1948) it was held that where a father let his 17-year-old daughter keep her own earnings after she went to work without accounting to her father for her expenditures, and where she paid for her own clothing, medical care and expenses, and was not required to secure parental approval for her social life, the facts afforded "strong support for an inference of emancipation" even though the daughter continued to live at home and did not pay her father for bed and board.

In *Burdick v. Nawrocki*, 21 Conn. Super. 272, 154 A. 2d 242 (1959), a 16-year-old minor, who was unemployed, lived and ate at home with his mother and stepfather; he received spending money from them, helped out with household chores and helped occasionally in his stepfather's place of business without compensation. This minor was held unemancipated.

In *Mesite v. Kirchstein*, 109 Conn. 77, 145 Atl. 753 (1929), a 16-year-old minor, who worked in a factory, resided with her parents and paid part of her wages to her parents while retaining the balance for clothing and spending money. She was held unemancipated from parental control as regards her right to recover against her mother for injuries she sustained in an auto accident.

In *New York Casualty Company v. The City Construction Company*, 16 Conn. Supp. 470 (1950), it was held that where an unmarried minor of 19 lived with his parents and turned his earnings over to them, the "evidence did not warrant a finding that the minor was emancipated."

In *Town of Plainville v. Town of Milford*, 119 Conn. 380, 177 Atl. 138 (1935), the court held that the desertion of a minor by his parents may emancipate a child. This case involved a five-year-old illegitimate child who was deserted by his mother and then raised by a foster family. It illustrates emancipation for the specific purpose of "acquiring a settlement" in a town in order to receive payments made for the support of paupers. See also *Town of Torrington v. Town of Norwich*, *supra*.

We have found no cases indicating whether Connecticut courts follow the general pattern of permitting medical treatment of minors without parental consent in emergencies, or whether Connecticut would accept the "mature minor" doctrine referred to in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

Connecticut law makes it a crime for any person who has "control and custody of any child under the age of sixteen years . . . wilfully or negligently [to] deprive such child of necessary food, clothing, or shelter . . .". Conn. Gen. Stat. Ann. § 53-20 (1960). In *State v. Clark*, 5 Conn. Cir. 699, 261 A. 2d 294 (1969) this statute was interpreted to embrace within its provisions "medical aid" even though such aid is not specifically mentioned. (This case involved the prosecution of a mother for "cruelty" under the above statute by neglecting to provide medical services to her two infants who were in an obvious state of "imminent danger.")

Physicians who work in public health departments or agencies or public or private hospitals or clinics are relieved from liability when treating minors for venereal disease without parental consent. Conn. Gen. Stat. Ann. § 19-89a (1968 Supp.)

Any child committed to the Department of Children and Youth Services by the Juvenile Court is financially supported by the state. When deemed in the best interests of such a child, the commissioner of that department, or his designee, "may authorize, on the advice of a physician licensed to practice in the state, medical treatment including surgery, to insure the continued good health or life of the child." Public Act No. 295 (effective Oct. 1, 1971).

Footnotes:

1. Prior to the *Griswold* decision, Connecticut was the only state that had a prohibition against the use of contraceptives.
2. *People v. Belous*, 71 Cal. 2d 954, 80 Cal. Rptr. 354, 458 P. 2d 194 (1969), *cert. denied* 397 U.S. 915 (1970).
3. Persons younger than 16 may not be issued a marriage license without the written consent of the judge of probate for the district wherein the minor resides. Conn. Gen. Stat. Ann. § 46-5f (1972 Cum. Supp.).

B. Laws Relating to Voluntary Sterilization

There is now no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

A statute which limited voluntary sterilization procedures to medical necessity was repealed effective October 1, 1971 (former Conn. Gen. Stat. Rev. § 53-33).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Connecticut State Department of Health's written policy on family planning consists of a one page statement entitled "Responsible Parenthood," dated June 13, 1968. A subsequent circular letter No. 37, dated September 30, 1968, was distributed to local health department directors with copies of the "Responsible Parenthood" statement and with an updated listing of family planning clinics in Connecticut. The statement describes the circumstances under which health workers may provide information about family planning services to potential patients, includes guarantees of freedom of choice to potential patients, and protects the "religious or moral scruples" of health workers: "If a parent inquires about family planning, a health worker may provide information about such resources. . . . Although workers may initiate discussion on the subject, they will not impose their views about family planning. . . ."

It is implicit in the policy that eligibility for family planning information is limited to parents, or at least, to married couples. For example, in one instance, the statement refers to family planning as "a decision which is best left to the joint judgment of husband and wife." In every other instance the statement refers to "a parent" or "parents" as the potential recipients of information. The statement makes reference to family planning informational services only, except that "when a parent . . . seems to give evidence of concern about moral or religious implications, he or she should be encouraged to discuss the situation with his or her clergyman and personal physician." No reference is made to the provision of family planning medical services or to direct referral to such medical services.

2. *Eligibility:*¹ Beyond the references to "parents" as potential recipients of family planning informational services noted above, the state neither recommends nor establishes any eligibility criteria for family planning services. Financial, social and geographical criteria for eligibility, as well as patient fees or payments, are determined by local health agencies.

3. *Administration:*² The Maternal and Child Health (MCH) Section, Community Health Division, has administrative responsibility for family planning activities in the State Department of Health. Professional staff assigned to family planning activities include: one public health program coordinator, 25–50 percent time; one public social work consultant, less than 10 percent time; two public health nursing consultants, less than 10 percent time; the Community Health Division Director, 10–25 percent time; and the MCH Section Chief, less than 10 percent time. The MCH Section and the Community Health Division perform the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; and allocation of MCH funds to local full-time directors of health departments for the purchase or provision of family planning supplies, equipment or other materials and for the support of medical family planning services.

4. *Financing:*³ All \$54,511 of new MCH funds allocated to the State Department of Health in FY 1971 which were federally earmarked for family planning were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds was \$440,210. An estimated \$86,251 were spent for family planning services. The Department received no specific appropriation for family planning from the state legislature and no other state funds were utilized by the state health agency for family planning.

5. *Voluntary Sterilization:* The Connecticut State Department of Health statement on "Responsible Parenthood," dated June 13, 1968, states: "Should questions be asked concerning voluntary sterilization for prevention of conception, it should be pointed out that the general statutes of Connecticut prohibit such operation except for specific indications." As of October 1, 1971, the revised criminal code for the State of Connecticut removed from the law Section 53–33 which restricted voluntary sterilization (See Sterilization Law above).

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey; figures on allo-

cations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Connecticut is contained in *Bulletins* 2124 and 2111 of the Connecticut State Welfare Department. These bulletins were issued June 1968 and May 1968, respectively. The Welfare Commission on February 27, 1967 issued a memorandum which established payment rates for family planning procedures but this memorandum has apparently been superseded, and *Bulletin* 2124 simply states that the Welfare Department "will pay for medically prescribed procedures and materials prescribed by a physician for family planning purposes." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department *authorizes* local welfare agencies to *refer* eligible recipients to family planning services and to *purchase* medical services for these recipients. The policy authorizes reimbursements to hospital outpatient clinics, voluntary agencies, and private physicians. Health departments are not authorized for reimbursement under the policy. There is no single, standard, state-wide reimbursement rate for medical family planning procedures.² The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients and potential recipients of such assistance and residents of low-income areas "who seek information on family planning are eligible for referral only." General Assistance recipients are not eligible for either medical or referral services. *Bulletin* 2124 states: "When a Public Assistance Recipient initiates a request for information concerning birth control resources in the community, the social worker will provide information concerning these resources."

According to *Bulletin* 2124, "The department will make known to welfare recipients generally the availability of family planning resources and services in the community." The social workers assigned the Aid to Dependent Children caseloads may inform any recipient who is the head of a family of the availability of family planning services and resources in the community. The Department, however, reported in the CFPPD survey that only adults and minors who are the "head of household" are eligible for family planning services; but the law in Connecticut provides that any minor who is 18 or

older may give effective consent to medical and health services.

4. *Administration*:⁴ The administrative responsibility for the family planning program is shared by the Bureau of Health Services and the Division of Child and Family Services in the Welfare Department. No staff are assigned either full- or part-time to family planning activities.

5. *Financing*:⁵ The Department received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Welfare has a written policy on voluntary sterilization. *Bulletin* 2124 contains the following:

Voluntary sterilization as a method of prevention of contraception when disease or physical jeopardy does not exist is prohibited by statute and cannot be approved by the department. Payments for voluntary contraceptive sterilization cannot be made to any agency, clinic, hospital, or individual.

However, the Department reported in the CFPPD survey that since October 1971 voluntary sterilization is no longer illegal in Connecticut and this event "may change agency policy in this regard."

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Connecticut Medicaid program family planning services are "Provided. Including drugs, supplies, and devices . . . May be provided by physicians or certified family planning clinics. Reimbursement on basis of fee schedule based on reasonable charge." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Law and Policy Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Delaware

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Delaware.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* In 1971 Delaware repealed its statute relating to contraceptives.¹ Thus, there is currently no state law specifically restricting or regulating the sale or distribution of contraceptives.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* As of the 1971 repeal of section 2502,² there is no law restricting advertising and display of contraceptives.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. See *Spruance v. Spruance*, 35 Del. Ch. 188, 113 A. 2d 877 (1955). However, any person who has attained the age of 19 can enter into binding contracts.³

By a statute which became effective in 1964, a married minor can consent to any lawful medical procedure, and parental consent is not required. Del. Code Ann. tit. 13, § 707 (Supp. 1970). The statutory age of consent to marriage is 18 for males and 16 for females. However, the statute provides that a marriage license shall not be issued to any male or female younger than 19 without parental consent.⁴ The age limitation does not apply where the parties are parents or prospective parents. Del. Code Ann. tit. 13, § 123 (Cum. Supp. 1970).

Another Delaware statute, which became effective in 1970, provides that a minor 12 years of age or older, who professes to be either pregnant or afflicted with a reportable communicable disease, can give effective written consent to diagnostic and therapeutic procedures and medical and surgical care. Del. Code Ann. tit. 13, § 708 (Supp. 1970). Although the statute is captioned "care and treatment for pregnancy or contagious diseases," the statutory language does not limit the type of care which may be provided. "Lawful therapeutic procedures" is defined as including abortions as permitted under Delaware law and any subsequent amendments thereof.

The physician may in his sole discretion provide or withhold from the parents or legal guardian or spouse of such minor such information as to diag-

nosis or treatment as the physician deems advisable, having primary regard for the interests of the minor. § 708.

Notice of intention to perform any operation on a minor under the venereal disease—pregnancy statute must be given the parents or legal guardian by telegram provided that "such operation may proceed forthwith after diagnosis if there is reason to believe that delay would endanger the life of such minor or there is a reasonable probability of irreparable injury." § 708.

The minor's consent is legally effective regardless of whether the minor's profession of pregnancy or venereal disease is subsequently medically confirmed. § 708.

Although no cases were found regarding the right of emancipated minors (other than married minors, who can consent as stated above) to consent to their own medical care, the State Department of Health and Social Services indicated in the CFPPD survey that married and emancipated minors are eligible for family planning services without parental consent and regardless of age. (See "Health Policy," "Eligibility," below.) In an early Delaware case, the court charged the jury as follows with respect to emancipation:

If, therefore, the defendant neglected or refused to support and maintain his son, or denied him a home, or discarded or abandoned him, so that he was forced to labor abroad to procure a living for himself, he is not upon any principle of law or justice entitled to the earnings of his son; because under such circumstances, the law will imply that the father has emancipated, or freed the son from his service, and conceded to him the right to enjoy the fruits and profits of his own labor. A father may also voluntarily and expressly emancipate his minor son, as by authorizing him to go out and labor for his own benefit.

Or emancipation may be implied from the conduct and relations of the parties, that is to say, the emancipation, or freedom of the son to labor for his own living, may be inferred from the fact that his father has knowingly permitted him to enter into contracts and manage business for himself, or on his own account for a considerable length of time . . . *Farrell v. Farrell*, 8 Del. (3 Houst.) 633 at 639-640 (1868).

The judge also charged the jury that the burden of proof was on the plaintiff, a son suing his father

for money the son had earned and sent the father for safekeeping, to show the fact of emancipation. The jury returned a verdict for the son.

Again, in *Bowring v. Wilmington Malleable Iron Co.*, 6 Pennewill's Rep. 332, 67 Atl. 160 (1907), the Delaware Superior Court said:

It is unquestionably the law of this state that a father may not only voluntarily and expressly emancipate his minor son, but such emancipation may be implied by law from circumstances or inferred from the conduct of the parent.

We have found no cases indicating whether Delaware courts follow the general pattern of permitting treatment of a minor without parental consent in emergencies or whether Delaware courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

By statute in Delaware, the Family Court may order the examination and treatment of any child alleged to be delinquent, neglected or dependent, and may order the costs thereof paid. Del. Code Ann. tit. 10, §§ 985 and 1179 (Cum. Supp. 1970).

Minor welfare recipients are eligible to receive family planning services and there is no parental consent requirement written in the Welfare Department Policy (See "Welfare Policy," "Eligibility," below).

Footnotes:

1. Del. Code Ann. tit. 16 §§ 2501 to 2504.
2. Ibid.
3. Del. Code Ann. tit. 6, § 2705 (Cum. Supp. 1970). The signature, seal and acknowledgement of a person of 18 years or older to any bond, other obligation and/or mortgage is valid and legally effective. Del. Code Ann. tit. 25, § 2102 (1953).
4. In *Samluk v. Gorecki*, 265 A. 2d 46 (Del. Super. 1970), it was held that a marriage entered into by a 17-year-old girl using a forged consent was not void. The husband's petition for an annulment was denied because he participated in the fraud.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures. Relevant case law, however, affirms the right of couples to voluntary sterilization.

Coleman v. Garrison, 281 A. 2d 616 (Del. Super Ct. 1971), was a malpractice action against a hospital and doctor by a husband and wife and their four children. The wife became pregnant and had a fifth child following performance on her of a voluntary sterilization procedure.

The defendants argued that voluntary sterilization was against the public policy of the state. The court specifically rejected this argument, stating:

"[T]he Supreme Court of the United States in *Griswold v. Connecticut*, 381 U.S. 479, 85 S. Ct. 1678, 14 L. Ed. 2d 510 (1965), held that a state may not proscribe the use of contraceptive devices by married couples. This decision recognizes a constitutionally protected right not to have children. Therefore, this Court cannot deny recovery on policy grounds which rest on the desirability of procreation." 281 A. 2d at 618.

Denying a motion to dismiss the complaint, a Delaware lower court held that the plaintiffs were entitled to claim damages not only for the wife's pain and suffering and for the medical expenses caused by her pregnancy, but also for the cost of support and education of the unwanted child. The court also said that the four children already born could recover for the loss of support and affection caused by the birth of a fifth child "should such change in family status be measurable economically."

The CFPPD survey indicates that the Division of Social Services authorizes referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients who wish it (See Welfare Policy section, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The current written policy on family planning of the Delaware State Board of Health consists of a one page policy statement entitled, "Policy on Family Planning," adopted March 25, 1965. The policy states in part: "Family planning, as it applies to protecting and maintaining the health of Delawareans, means the furnishing of information and medical assistance by qualified professionals to those people who: 1) Desire to have children; 2) Wish to space the interval between children in accordance with planned family requirements; 3) Because of hazards to health which are known to postpone pregnancy [sic] . . . The information and/or medical assistance to be provided should be in conformance with the desires and beliefs of individuals involved. . . . The Board of Health declares its intent to cooperate with individuals, or agencies whose philosophy and goals are essentially the same as expressed herein. . . . It shall be the policy of the Board that its professional personnel will henceforth offer families [family planning information], and especially to mothers with new-born children and [will] furnish advice and referral in those instances where such help is requested. . . ."

The policy statement encompasses the family planning information and referral services, *where the request is initiated by the potential patient*. The policy makes no reference to the initiation of information or referral services by health workers.

2. *Eligibility*: The policy statement cited above appears implicitly to limit eligibility for information

and referral services to married persons ("people who . . . desire to have children . . . [or who] wish to space the interval between children in accordance with planned family requirements . . ."), unless clause 3 cited above is interpreted broadly to include unmarried adults or minors who postpone pregnancy in order to avoid health hazards.

In contrast with the State Board of Health's policy statement, the State Department of Health and Social Services indicated in the CFPPD survey that social eligibility requirements for family planning services, as established by the Department, are as follows: All categories of adults are eligible for services; all minors over age 18 are eligible for services, *with* parental consent; except that married and emancipated minors are eligible *without* parental consent and *regardless of age*. There are no financial or geographical limitations on eligibility. No patient fees or payment are required for family planning services, as they are "prohibited by grant specifications" (CFPPD survey).

3. *Administration*:¹ The Office of Maternal and Child Health Services, Division of Physical Health, has administrative responsibility for family planning services in the Department of Health and Social Services. Professional and clerical staff assigned to family planning activities include the following: one public health nurse, 10–25 percent time; one public health nurse, full-time; two registered nurses, 10–25 percent time; one licensed practical nurse, 10–25 percent time; and one clerk-typist, 10–25 percent time. The Office performs the following functions in support of family planning activities: consultation; distribution of public educational materials; home nursing visits; grants to the Delaware League for Planned Parenthood; clinic operations in two health units and pregnancy testing in three health units.

4. *Financing*:² \$10,737 of new MCH funds were allocated to the Department of Health and Social Services for FY 1971 which were federally earmarked for family planning. No information concerning the obligation of these funds is available. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$200,459. An estimated \$8,500 was spent for family planning services. The Department received a \$100,024 appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Department for family planning services.

5. *Voluntary Sterilization*: The Department of Health and Social Services has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.

2. Information contained in this section was reported by the state health agency in the CFPPD survey; figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Delaware is contained in the *Policy Manual of Services to Families and Children* of the Division of Social Services in the Department of Health and Social Services. Section 2315, dated January 1970, and Section 7115, dated January 1971, cover family planning services. Section 2315 states: "Services geared toward prevention or reduction of unwanted or unplanned births are essential. Service workers will initiate discussion of available information and resources for family planning on the basis of the social study and casework plan with the family without regard to marital status, age or parenthood." Payment for family planning services is authorized by Section 1005 of the Vendor Payments Manual. The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Division of Social Services *authorizes* local welfare agencies to *refer* eligible public assistance recipients to family planning services. Local agencies are *authorized* but not required to *purchase* medical family planning services for these individuals.

The policy authorizes reimbursements to hospital outpatient clinics, voluntary agencies, and private physicians but not to health departments. There is no single standard, state-wide reimbursement rate for medical family planning procedures.² The state has no contracts with providers of services for the provision of family planning services.

3. *Eligibility*:³ Except for recipients of Aid to the Permanently and Totally Disabled, all current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance, and residents of low-income areas are eligible for referral services only. General Assistance recipients are eligible only for referral services.

There are no additional limitations that affect the provision of services to adults or minors. According to Section 7115, family planning "services must be available without regard to marital status, age or parenthood."

4. *Administration*:⁴ The Bureau of Family Services and the Bureau of Assistance Payments share responsibility for the administration of the family planning program. No staff are assigned either full- or part-time to family planning. Family planning activities of the two bureaus include the training of local welfare staff and the development and distribu-

tion of educational materials as well as interagency liaison.

5. *Financing*:⁵ The Division of Social Services received no specific appropriations for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Division of Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Division *authorizes referral* for and the *purchase* of voluntary sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Delaware Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices when provided under supervision of a physician. . . . Reimbursement to physician on basis of usual and customary charges." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Law and Policy Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Florida

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: There is no law establishing a state family planning program in Florida.¹

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: None found.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 21. *Beekman v. Beekman*, 53 Fla. 858, 43 So. 923 (1970); *Riley v. Holmer*, 100 Fla. 938, 131 So. 330 (1930). A minor who "is married, has been married, or subsequently becomes married" may contract, sue and perform all acts that he could do if he were not a minor. Fla. Stat. Ann. § 743.01 (as amended 1971 Laws Ch. 71-147).

There is a judicial procedure available whereby the courts may remove the disabilities of minority for minors older than 18 on petition filed by the natural or legal guardian, and if there is none, then by the next friend of the minor. Fla. Stat. Ann. § 62.011 (1969). ("Next friend" has been defined by the Florida Supreme Court as an "officer of the court, especially appearing to look after the interests of the minor whom he represents." *Youngblood v. Taylor*, 89 So. 2d 503 (1956).)

Although Florida appears to follow the general rule requiring parental consent for medical treatment of a minor,² there are a number of exceptions: Parental consent is not required where a person's disabilities of nonage have been removed by his or her marriage or by judicial decree. Attorney General's Opinion No. 071-220 (August 5, 1971). In case of emergency, it is the Attorney General's opinion that a doctor may treat a minor without parental consent. *Ibid.* A Florida statute permits emergency treatment of public school pupils without parental consent. Fla. Stat. Ann. § 230.23 (Cum. Supp. 1971).

A minor who is or professes to be afflicted with (or exposed to) a communicable disease (e.g. V.D.) can consent to the provision of medical or surgical care or services by a hospital or public clinic, or the performance of medical or surgical care or services by a licensed physician. Fla. Stat. Ann. § 384.061 (Cum. Supp. 1971) (as amended effective Oct. 1, 1971). Although this statute provides that the con-

sent of parent or guardian shall not be necessary, it requires the physician to "make a sincere attempt to persuade the minor to permit him to divulge the nature of the condition to the parent or parents of the minor." The statute further provides that the physician (or member of the staff of a hospital or public clinic acting upon the advice and direction of a treating physician) may inform the spouse, parent, custodian or guardian of any such minor as to the treatment given or needed. "Such information may be given to or withheld from the spouse, parent, custodian, or guardian without the consent of the minor patient."

Florida has a statute which makes it a crime for a person to deprive his child or ward of "necessary treatment and attention." Fla. Stat. Ann. §§ 828.04, 828.042 (Cum. Supp. 1971).

The Department of Health and Rehabilitative Services is authorized to provide medical services to needy children through the Division of Family Services. Fla. Stat. Ann. § 409-266 (Cum. Supp. 1971).

No cases were found indicating whether Florida courts would accept the "mature minor doctrine" described in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors, or whether Florida courts would follow the general pattern of permitting medical treatment without parental consent for "emancipated" minors (in addition to those who are married or emancipated by judicial decree, who may consent as indicated above).

The Florida health department states, however, that married and emancipated minors are eligible for service without parental consent. (See Health Policy section, below). A recent Florida case holds that a minor who earns money and controls his own finances may be emancipated even though still living at home. *Owen v. Owen*, 234 So. 2d 165 (Fla. D. Ct. of App. 1st D. 1970), *cert. denied*, 237 S. 2d 763 (Fla. Sup. Ct. 1970). The *Owen* decision relied upon the Florida Supreme Court decision in *Jackson v. Citizens Bank & Trust Co.*, 53 Fla. 265, 44 So. 516 (1907) that a son may continue to be a member of his father's family and live at home and yet be entitled to keep his own earnings. The court in *Owen* explicitly refused to follow an earlier Florida ruling that emancipation can be proved only by showing "a complete severance of the filial tie." See *Meehan*

v. Meehan, 133 So. 2d 776 (Fla. D. Ct. App. 2d D. 1961).

The Division of Family Services reports that in providing family planning services for welfare recipients, the legal age for the provision of services without parental consent is 21, but "many providers use discretion in the enforcement of this age limit." (See Welfare Policy Section, Eligibility, below.)

Footnotes:

1. Until 1967 the Department of Public Welfare had a proviso to its welfare statute stating that any request for birth control services on the part of parents with dependent children would not be considered a violation of the "suitable home rule" which permits welfare authorities to take children from their parents if the home is found unsuitable. Fla. Stat. § 409.18 (1965). This section was later repealed and reenacted in 1970 in §§ 409.235, 409.245, and 409.255. No mention is made of requests for birth control services in these sections; however, we have been advised by the Attorney General of Florida that the failure to reenact the proviso relating to requests for birth control services does *not* indicate that such a request will now reflect a failure to provide a suitable home with a stable moral environment for the child. (Letter from Robert Shevin to Harriet Pilpel, October 4, 1971).
2. See *Bowers v. Talmage*, 159 So. 2d 888 (Fla. Dist. Ct. App. 3d D. 1963); *Brown v. Wood*, 202 So. 2d 125 (Fla. Dist. Ct. App. 2d D. 1967).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures. There is relevant case law affirming the legality of voluntary sterilization.

Jackson v. Anderson, 230 So. 2d 503 (1970) involved the question of whether recovery could be had in the absence of other damages, when a healthy child was born following a sterilization operation. The theory of recovery was negligence and breach of a specific warranty to sterilize the mother. It was held that the action was proper and that there is no public policy preventing damages from being assessed for the birth of an unplanned, healthy child.

Citing *Christensen v. Thornby*, 192 Minn. 123, 255 N.W. 620 (1934), the court stated that a contract to perform a sterilization operation does not contravene public policy.

There are two other recent cases involving voluntary sterilizations. *Vilord v. Jenkins*, 226 So. 2d 245 (Dist. Ct. App. Fla. 1969) presented the question whether the statute of limitations was a bar to a suit brought against a doctor alleging negligence and breach of warranty in the performance of a salpingectomy for contraceptive purposes.

Lane v. Cohen, 201 So. 2d 804 (Dist. Ct. App. Fla. 1967) was a suit based on the alleged negligence of a physician who performed a vasectomy. The court held that the mere fact that the operation failed was

not sufficient proof of negligence so as to permit recovery against the physician.

It should be noted that in both cases the court assumed that there was no question about the legality of voluntary sterilization.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The current written policy on family planning of the Florida Division of Health consists of a set of *Standards and Operating Procedures for Family Planning Services*, dated February 1965, and a subsequent "Preface" to the *Standards*, dated January 1970. Together the "Preface" and the *Standards* cover the following areas of policy: eligibility; freedom from coercion; respect for the religious and moral convictions of health workers; freedom of choice of contraceptive methods, including the rhythm method; referral to additional services including infertility services; patient fees; scheduling of family planning clinics; acceptable family planning methods, including sources of further information; and standards for family planning services in independent clinics or as part of other health department clinics. However, the *Standards* state ("II. Policies to be followed."): "It is to be understood that the policies set forth in this Manual of Standards are not mandatory."

2. *Eligibility*: The *Standards* cited above, dated February 1965, state that where family planning services are provided by county health departments, "these services will be available to all persons who are for various reasons unable to obtain this care from a private physician, hospital or clinic. . . . the decision as to eligibility will be made by the physician after consultation with the nurse, patient and husband based on medical and/or socio-economic reasons." The "Preface" cited above, states that "family planning services shall be available to any person living in Florida, without specific reference to residence status . . . (and) without regard to race, religion, nationality, maternity or marital status."

As reported by the Division of Health in the CFPPD survey, financial and geographical eligibility requirements and patient fees are recommended by the Division and determined by local health agencies. The Division recommends that services be provided for those who cannot afford private medical care and that local agencies adopt county residency as a geographical eligibility requirement. As reported in the CFPPD survey, the Division has established the following social eligibility criteria: All categories of adults are eligible for family planning services except unmarried adults without children. Married and emancipated minors are eligible for family planning services without parental consent; all other minors, including those who have been

pregnant or who have children, require parental consent. No minimum age requirement is established for services to minors. The Division reported in the CFPPD survey that patient fees are determined locally; however, in the *Standards* cited above, "no one will be denied advice and/or supplies if unable to pay. However, a small fee is desirable and may be accepted on an ability to pay basis if local regulations permit" (emphasis quoted).

These apparently inconsistent requirements suggest that Division of Health eligibility policy for family planning services has been in a state of flux over the past several years.

3. *Administration*:¹ The Bureau of Maternal and Child Health and the Division of Family Services, Department of Health and Rehabilitation Services, have administrative responsibility for family planning services in the State Division of Health. Professional staff assigned to family planning activities include the following full-time personnel: two consulting physicians; one health program specialist; one nursing consultant; and one health educator. The Bureau performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing*:² \$299,169 of new MCH funds were allocated to the state for FY 1971 which were federally earmarked for family planning. The Division of Health reported in the CFPPD survey that these funds were received too late to be used in FY 1971. The total allocation to the state of nonearmarked MCH funds was \$1,359,924. An estimated \$168,794 of these funds were spent for family planning services. The Division of Health received a \$200,000 appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Division for family planning.

5. *Voluntary Sterilization*: The Division of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey; figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW, January 22, 1971).

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare

family planning policy in Florida is contained in Chapter 600 of the *Division of Family Services Manual*, dated June 1968. An additional policy statement is contained in *Operations Letter No. 1623* of April 29, 1968 which states: "The fact that a client asks for or shows an interest in being referred for family planning services shall not be used by the worker as a basis for questioning suitability of the home." Chapter 600 of the *Manual* states that "the primary and central responsibility of the District is to make certain that every childbearing age client understands, to the extent possible, and promptly receives, to the extent desired, family planning services." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Division of Family Services *recommends* that local welfare agencies *refer* eligible public assistance recipients to medical family planning services and also *recommends* that these agencies *purchase* family planning services for eligible recipients.

The policy, however, authorizes reimbursements only to private physicians and no reimbursement is made to hospital outpatient clinics, voluntary agencies, or to health departments. Public assistance recipients are expected to avail themselves of family planning services available without cost through health departments or other agencies. According to Chapter 600, only when free services are unavailable, "or in unusual situations and circumstances," does the policy authorize the purchase of services from private physicians.

Chapter 600 contains a single, standard, statewide reimbursement rate for family planning procedures which pays \$20 for an initial visit and \$7.50 for subsequent visits.² "Included in the initial fee consideration is any required lab work and the intrauterine device if prescribed. Prescribed pills are assumed to be available from the County Health Department." There are currently no contracts with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, potential recipients of such assistance, and residents of low-income areas are eligible for referral services only. There is no state-administered General Assistance program in Florida.

There are no additional limitations which affect the provisions of services to adults. Chapter 600 provides that "When services for youth or incompetent persons are involved, the discussion should always be directed through the parent or legal guardian, if feasible." The Division reported that the legal age for the provision of services without parental con-

sent is 21, but also indicated that "many providers use discretion in the enforcement of this age limit."

4. *Administration:*⁴ The Division of Family Services has administrative responsibility for the family planning program. No staff are assigned either full or part-time to family planning, but family planning activities of the Division include the training of local welfare staff, the development and distribution of educational materials and participation in the development of a state-wide family planning service system.

5. *Financing:*⁵ The Division of Family Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:*⁶ The Division of Family Services has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Florida Medicaid program, family planning services are "Provided . . . Reimbursement to physicians on basis of fee schedule." The Florida legislature has appropriated \$3,933 as matching funds for family planning services provided under the Medicaid program in fiscal year 1972. The 1969 City University of New York study reported that Florida has an estimated expenditure of \$2,205 for family planning services under Title IV-A of the Social Security Act in fiscal year 1969. Projected fiscal year 1970 expenditures were \$1,915 for Title XIX family planning services and \$1,312 for Title IV-A family planning services expenditures. (For additional information on Medicaid, see Federal Law and Policies Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.
6. Ibid.

Georgia

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* In 1966 Georgia enacted the Family Planning Services Act authorizing state and local Health Departments and Departments of Family and Children Services to provide "family planning services" within the limitations of funds available. Ga. Code Ann. §§ 99-3101-3109 (1970 Cum. Supp.)

"Family planning services" under the statute means interviews, counseling, distribution of literature, referrals for consultation, examination, medical treatment and prescriptions and, to the extent prescribed, distribution of rhythm charts, drugs and devices, all with respect to birth control, family planning and infertility.

Under this Act, the following categories of persons are eligible to receive such services: married persons; one who is the parent of at least one child; one who is pregnant; and, any person requesting such services (the last category added by 1968 amendment).

These services may be rendered at no cost to the recipient. Any person may refuse to accept family planning services without jeopardizing his or her right to receive public assistance and other public benefits.

The law authorizes the State Department of Health and the State Department of Family and Children Services to develop plans and programs, and to promulgate rules and regulations to carry out the provisions of the law. The plans and programs include a training program giving employees of these Departments, who are likely to come in contact with persons desiring family planning services, complete information regarding family planning and birth control.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* A person is a minor until he reaches the age of 21. Ga. Code Ann. § 74-104 (1964). However, in 1971 Georgia enacted a comprehensive statute called the Georgia Medical Consent Law. Ga. Code Ann. ch. 88-29 (as amended effective July 1, 1972). Under

this law, consent to any lawful surgical or medical treatment may be given by:

- (a) Any adult, for himself;
- (b) Any parent, whether an adult or a minor, for his minor child;
- (c) Any married persons [sic], whether an adult or a minor, for himself, and for his spouse;
- (d) Any person temporarily standing *in loco parentis* whether formally serving or not, for the minor under his care and any guardian, for his ward;
- (e) Any minor 18 years of age or over, for himself;
- (f) Any female regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth;
- (g) In the absence of a parent, any adult, for his minor brother or sister;
- (h) In the absence of a parent, a grandparent for his minor grandchild. Ga. Code Ann. § 88-2904 (as amended effective July 1, 1972).

Although the statute now specifically authorizes female minors to consent to contraceptive services and to treatment given in connection with pregnancy, it does not enable minors to consent to abortion. Section 88-2902 (1971).

The 1971 law also provides that "a consent to surgical or medical treatment or procedures, suggested, recommended, prescribed or directed by a duly licensed physician, will be implied where an emergency exists. For the purposes hereof, an emergency is defined as a situation wherein, (a) in competent medical judgment, the proposed surgical or medical treatment or procedures are reasonably necessary, and (b) a person authorized to consent . . . is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected, or could reasonably result in disfigurement or impair facilities." Ga. Code Ann. § 88-2905 (1971).

The 1971 statute further provides:

The provisions of this Chapter shall be liberally construed, and all relationships set forth herein shall include the adoptive, foster and step-relations as well as the natural whole blood, the relationship by common-law marriage as well as ceremonial marriage. A consent by one person so authorized and empowered shall be sufficient. Any person acting in good faith shall be justified in relying on the representations of any person purporting to give such a consent, including, but not limited to, his identity, his age, his marital status, his emancipation, and his relationship to any other person for whom the consent is pur-

portedly given. A consent to medical and surgical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given, and which is duly evidenced in writing and signed by the patient or other person or persons authorized to consent pursuant to the terms hereof, shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations of material facts in obtaining the same. Ga. Code Ann. § 88-2906 (1971).

Georgia also has a 1971 law providing that a minor who is or professes to be afflicted with a venereal disease can consent to medical or surgical care by a licensed physician. The physician may but need not inform the spouse, parent, custodian or guardian of the minor as to the treatment given or needed, and such information may be given or withheld even over the express refusal of the minor patient. Ga. Code Ann. §§ 74-104.2, 74-104.3 (Cum. Supp. 1971).

As stated above under "Laws Establishing Family Planning Programs," the Family Planning Services Act authorizes the Georgia Department of Public Health, among other agencies, to offer family planning services to persons who are married, or the parent of at least one child, or pregnant, or to "any person requesting such services." Ga. Code Ann. § 99-3103 (1970 Cum. Supp.) (The latter subsection was added to the original 1966 Family Planning Services Act by amendment in 1968.)

The state health and welfare departments provide contraceptive services to *all* minors without parental consent (See Health and Welfare Policy sections, below).

B. Laws Relating to Voluntary Sterilization

In 1966, Georgia enacted a Voluntary Sterilization Act which authorized licensed physicians and surgeons to perform sterilization procedures on the request of any married person. This Act was repealed in 1970 and replaced by a new law authorizing sterilization of two classes of people: 1) any person 21 years of age or over or less than 21 years of age if legally married; and 2) persons, whether or not 21 years of age, who are "irreversibly and incurably mentally incompetent." Ga. Code Ann. §§ 84-931 to 935 (Supp. 1970).

Entirely different procedures are prescribed for the two classes of people; the discussion here will be limited to the first class, since the sterilization of incompetents is outside the scope of this report.

The request for sterilization must be made in writing by the person seeking the procedure and by his or her spouse, if married and if such spouse can be found after reasonable effort. Prior to or at the time of such request, a full and reasonable medical explanation must be given by the physician to the patient as to the meaning and consequence of the operation. The physician performing the operation

must be duly licensed to practice medicine and surgery and must consult or collaborate with at least one other physician also so licensed. §§ 84-932; 84-935.

The statute does not require the operation to be performed in a hospital nor is a waiting period prescribed between the request and the actual performance of surgery.

The statute exempts licensed physicians and all other persons legally participating in the performance of the procedures covered by it from criminal or civil liability except for negligence. § 84-935.1.

The act specifically excepts from the procedures it prescribes "medical or surgical treatment for sound therapeutic purposes . . . which treatment may involve the nullification or destruction of the reproductive functions at the same time that it serves such sound therapeutic purposes." § 84-935.1. In other words, if an operation such as removal of a cancerous womb or prostate gland is performed, the procedures of the Act need not be followed although the operation may result in sterilization of the patient.

The statute does not require a hospital to admit a patient for sterilization. Nor is any physician or staff member of a hospital required to participate in a sterilization procedure if he objects to such sterilization procedure on moral or religious grounds. Refusal to participate in such procedures "shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person." § 84-935.2.

The statute contains no limitation on the grounds for which voluntary sterilization is permitted.

We have seen that Georgia has another statute authorizing state and local Health Departments and Departments of Family and Children Services to provide "family planning services" within the limit of available funds. "Family planning services" are defined as including "referral to licensed physicians or local health departments for consultation, examination, tests, medical treatment and prescriptions for the purposes of birth control, infertility and family planning." (See Laws Establishing Family Planning Programs, above.) It is not clear whether voluntary sterilization is included. However, the CFPPD survey indicates that the Department of Family and Children Services requires referral and payment for sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them. *Minors:* The 1971 Georgia Medical Consent Law, which gives various categories of minors the right to consent to medical treatment (see section on Laws Relating to Contraceptive Services to Minors, above) does not apply to the subject of sterilization "which subject shall continue to be governed by existing law independently of the terms and provisions

of this Chapter." Ga. Code Ann. § 88-2902 (1971).

We have seen that the Voluntary Sterilization Act authorizes the procedure to be performed only upon persons 21 years of age or over or less than 21 years of age if legally married. Ga. Code Ann. § 84-932 (Supp. 1970).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The only written policy on family planning of the Georgia Department of Public Health consists of a program manual entitled *Policy and Procedures*, dated June 1965. This document has been superseded in large part by Georgia laws enacted in 1966 (and amended in 1968 Georgia Code Ann. §§ 99-3101 to 99-3109). With respect to eligibility requirements the 1965 manual is specifically contradicted (See Laws Relating to Contraception, above).

The 1966 statute authorizes the Georgia Department of Public Health, local health departments and Departments of Family and Children Services to provide family planning services within the limitations of funds available. Section 8 of 99-3108 authorizes and directs the state health and welfare agencies "to adopt and promulgate laws and regulations to carry out the provisions of this Act. Such rules and regulations shall provide the necessary requirements and guides for county and district Departments of Public Health and Departments of Family and Children Services."

2. *Eligibility:*¹ Policy on social eligibility criteria for family planning services is established by the Department of Public Health. Under the Department's policy all categories of adults and all minors, without parental consent, are eligible for family planning services and no minimum age requirement is made for services to minors. Financial and geographical eligibility requirements are determined by local agencies. No patient fees are utilized in health agency family planning programs.

3. *Administration:*² The Maternal Health Service has administrative responsibility for family planning services in the Department of Public Health. Professional and clerical staff assigned to family planning activities include the following full-time personnel: the Medical Service Director; two consultant nurses; one nutrition consultant; one health program representative; and four stenographers. The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$316,201 of new MCH funds were allocated to the Department of Public Health for FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds was \$1,319,584. An estimated \$501,608 of these funds were spent for family planning.

The Department received a \$250,000 appropriation for family planning from the state legislature for FY 1972. The appropriation is to be used to match Social Security Act Title IV-A funds. In FY 1972 state funds of approximately \$167,000 will be used to match Federal Social Security Act Title V Project Grant Funds.

5. *Voluntary Sterilization:* The state health agency has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Georgia is contained in a series of *County Letters* issued by the State Department of Family and Children Services. These *County Letters*, which were sent to county welfare directors, field staff, and state staff, are Number 164, February 12, 1968; Number 190, May 29, 1968; Number 326, September 21, 1971. In addition, there is a *Director's Memorandum* of March 3, 1971 which also was sent to county directors, field staff and state staff which states that county welfare directors are encouraged "to offer family planning information, counseling, referral and follow-up services to all Department clients of childbearing age and to tell all others who request it. Take note that 'Family Planning information and counseling' means not only that pertaining to contraception but information and advice on the related areas of sterilization, abortion, infertility and sex education, as well."

An interagency agreement between the Health Department and the Family and Children Services Department on the provision of family planning services was signed on July 2, 1971. Paragraph III of the agreement states: "The State Health Department through its county departments will be responsible for the provision of clinical, medical, public health nursing services and contraceptive supplies for family planning." The policy documents contain

no statement on the objectives of the family planning program.

2. *Referral and Purchase Provision:*¹ Under the policy, the Department of Family and Children Services *requires* local welfare agencies both to *refer* eligible public assistance recipients to medical family planning services and to *purchase* family planning services for these individuals. The policy, however, authorizes reimbursement only to private physicians; no reimbursement is authorized for hospital outpatient clinics, health departments, or voluntary agencies.²

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as applicants, past recipients, potential recipients of such assistance, and residents of low-income areas are eligible under the policy. General Assistance recipients are also eligible under the policy.

There are no additional limitations that affect the provision of services to adults. The Department reported that under the "1971 Georgia Medical Consent Law all minors are eligible without parental consent for services related to pregnancy and childbirth."

4. *Administration:*⁴ The Family Planning Section in the Department of Family and Children Services is responsible for the administration of the welfare family planning program. A Family Planning Chief and three Family Planning Representatives are assigned full-time to family planning activities. Family planning activities include the training of local welfare staff, development and distribution of public educational materials, and liaison and coordination with the Health Department and OEO.

5. *Financing:*⁵ The Department of Family and Children Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Family and Children Services has a written policy on voluntary sterilization. *County Letter No. 326* states that "Sterilization is indicated when contraceptive methods have failed; have been unsatisfactory, or not suitable; when pregnancy is likely to endanger health; when pregnancy prevents fulfilling parental responsibilities; or when there is likelihood of transmitting hereditary defects. . . . One of the preferred times for sterilizations is after the delivery of a baby when it is common practice within 12 to 48 hours to tie the tubes." The Department indicated in the CFPPD survey that it requires *referral for* and the *purchase of* sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Georgia Medicaid program, family planning services are "Not Provided." However, this publication is based on data of January 1970 and the Georgia Medicaid program may have been modified since that date. (For additional information on Medicaid, see Federal Law and Policy Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Hawaii

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Hawaii has a law requiring the department of health to "furnish to each applicant for a marriage license information, to be provided by the department, relating to population stabilization, family planning and birth control." Hawaii Rev. Laws § 572-5 (Supp. 1971).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found. Hawaii does have a statute prohibiting the sale of prophylactics by vending machine. Prophylactics are defined as devices, appliances, or medicines used for the prevention of venereal disease. Hawaii Rev. Laws §§ 760-1 to 760-3 (Supp. 1965) ¹

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Hawaii has a statute banning the outdoor advertising of any articles or means of preventing conception and the outdoor advertising of any information on medicines for the prevention of venereal disease. Hawaii Rev. Laws § 445-119 (Supp. 1965) ²

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority in Hawaii is 20. Hawaii Rev. Laws § 577.1 (1968). However, a female may marry at 18 without parental consent. Hawaii Rev. Laws § 572-2 (1971 Supp.)

No cases were found specifically relating to medical care of minors, but a recent Hawaii case contains a dictum to the effect that a physician must secure the consent of a minor's parent or legal guardian before operating. *Nishi v. Hartwell*, 52 Hawaii 188, 473 P. 2d 116 (1970).

A Hawaii statute provides that a minor 14 or over who is or professes to be afflicted with a venereal disease may consent to medical treatment of the venereal disease and no other person's consent shall be necessary. Hawaii Rev. Laws § 577A-2 (1971 Supp.)

A female minor 14 or over who is or professes to be pregnant may consent to examination and treatment for pregnancy and no other person's consent shall be necessary. Hawaii Rev. Laws § 577A-2 (1971 Supp.) This "shall not include surgery or any treatment to induce abortion except as permitted under section 768-7." Hawaii Rev. Laws § 577A-1

(1971 Supp.). Former section 768-7, which authorized abortion to save the life of the woman, has been repealed and replaced by § 453-16, which permits abortions to be performed by licensed physicians in licensed hospitals for any reason. Neither former section 768-7 nor the new section 453-16 contains any age requirements. Accordingly § 577A-1 (read with § 577A-2) would appear to authorize a girl of 14 or over to consent to abortion for any reason; the Deputy Attorney General of Hawaii agrees with this analysis. *Letter from Deputy Attorney General Benjamin M. Matsubara to Harriet F. Pilpel*, June 20, 1972. This does not necessarily mean she can consent to contraception. (See discussion of "Treatment of Minors Related to Pregnancy" in Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.)

Hospitals, clinics or physicians must inform the spouse, parent, custodian or guardian of any patient younger than 18 who is diagnosed as pregnant or afflicted with venereal disease, and "such information shall be given to the spouse, parent, custodian or guardian without the consent of the minor patient and even over the express refusal of the minor patient." Hawaii Rev. Laws § 577A-3 (1971 Supp.) If the minor patient is not diagnosed as pregnant or afflicted with venereal disease, withholding of such information "shall be within the discretion of the staff of such hospitals or . . . clinics or . . . physicians . . ."

A bill which would have enabled minors to consent to "the diagnosis, examination and administration of medication for general medical and dental care except that it shall not include surgery or any treatment to induce abortion" was passed by the Hawaii legislature in 1972 but vetoed by the Governor. *Letters from Deputy Attorney General Benjamin M. Matsubara to Harriet F. Pilpel*, May 26, 1972 and June 20, 1972.

No cases were found indicating whether Hawaii courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies and where the minors are "emancipated," or whether Hawaii courts would accept the "mature minor doctrine" described in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors. However, an early Hawaii case recognizes that a girl who has "reached the age

when she is capable of exercising a sound discretion" may be emancipated. In re Nei Kamarawa, 6 Hawaii 386 (1883).

Footnotes:

1. Under an earlier codification, these sections were coded 302A-1, 302A-2 and 302A-3.
2. Under an earlier codification, this was § 155-128.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

There is a written state Health Department policy of referral of men and women for voluntary sterilization. (See the Health Policy section below). There is also a written state Welfare Department policy of reimbursement for voluntary sterilization. The CFPPD survey indicates that the Department requires referral and payment for sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it, and provides reimbursement. (See Welfare Policy section below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current state health agency policy on family planning in Hawaii consists of a one paragraph "Policy Statement on Family Planning" adopted by the Department of Health in 1965. The policy statement is as follows: "The Hawaii State Health Department includes family planning as an integral part of their health programs, makes sufficient funds and personnel available for this purpose, and insures such freedom of choice of methods that persons of all faiths have equal opportunities to exercise their choice without offense to their consciences. Family planning is defined to include genetic counseling, fertility control, and sterility correction."

2. *Eligibility:*¹ Unofficial policy on eligibility was elucidated by the Hawaii Director of Health in answer to several questions about eligibility requirements and patient fees in a January 1971 letter to the Region X Program Management Officer, National Center for Family Planning Services, DHEW. The letter stated that "eligibility requirements are uniform throughout the MIC project, which is in two different counties." (It is unclear whether eligibility requirements differ outside the MIC area). Social eligibility requirements for family planning established in Department of Health policy are as follows: all categories of adults are eligible for family planning services; all categories of minors are eligible for family planning services except that all unmarried minors must have parental consent.

There are no specific financial eligibility requirements; however, services are intended for low-income groups. There are no geographical requirements for eligibility; however, clinics are located in low-income areas. No fees are charged for family planning services.

3. *Administration:*² The Children's Health Services Division has administrative responsibility for family planning services in the Department of Health. Professional staff assigned to family planning activities include the following full-time personnel; one project director; one public health nurse; one licensed practical nurse; one social worker; and one health educator. Other Health Department personnel include a nutritionist, less than 10 percent time; one stenographer, full-time; and various staff from the Children's Health Services Division, less than 10 percent time. Other staff authorized include two health aides, 50 percent time; and one clerk, 50 percent time. The Department of Health performs the following functions in support of family planning activities: consultation; development and distribution of public educational materials; provision of state matching funds to support Federal grants; provision of personnel to augment family planning staffs; and overall program direction.

4. *Financing:*³ The Department of Health received \$16,103 of new MCH funds for FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$22,997. An estimated \$12,147 of these funds were spent for family planning services. The Department received no specific appropriation for family planning from the state legislature. Additional state funds were utilized by the Department for family planning services in FY 1971 as follows: public health nursing, \$17,611; health education office, \$5,348; children's health services division, \$10,048.

5. *Voluntary Sterilization:*⁴ The Department of Health has a written policy on voluntary sterilization which encompasses referrals for sterilization for males and females, but does not include provision for the purchase of voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Services, DHEW), January 22, 1971.
4. Information contained in this section was reported by the state health agency in the CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Hawaii is contained in Section 3449, dated June 1967, of the *Hawaii Department of Social Services Manual* and in Sections 5040 thru 5043 of the *Manual*, dated September 1970. Section 5041 states that payments are approved "for medical services and supplies related to: 1) Birth control; 2) Spacing of children; 3) Infertility correction; 4) Abortion; 5) Sterilization."

According to subsection 5040.2, "The objective of family planning services is to promote and safeguard individual family and community health and social well-being by providing individuals: a) The freedom of choice to determine the spacing of children and family size; b) Knowledge of recognized scientific methods of family planning; c) Knowledge of where to get birth control advice, service and supplies."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning resources and to *purchase* services for eligible public assistance recipients. Reimbursement is made to hospital outpatient clinics and private physicians but not health departments and voluntary agencies.² The Department has no contracts or other formal arrangements with providers of family planning services. There is no single, standard statewide reimbursement rate for medical family planning procedures.

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as applicants, past recipients of such assistance and residents of low-income areas and general assistance recipients are eligible for medical services under the policy. Potential recipients of federally-aided assistance, however, are not eligible for medical family planning services. The Department reported that "applicants who are denied financial assistance or medical assistance" are eligible for referral services only.

There are no additional limitations that affect the provision of services to adults. Except for married minors, all other minors must have parental consent.

4. *Administration:*⁴ Responsibility for the administration of the family planning program is shared by the Office of Medical Care Administration and the Program Development Office—Family Services. The administrators of the two agencies and three other staff members devote less than 10 percent of their time to family planning activities. Family planning activities of the two agencies include the training of local welfare staff, the development and distribution of educational materials, and the promotion of family planning services in the State.

5. *Financing:*⁵ The Department of Social Services received no specific appropriations for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Social Services has a written policy on voluntary sterilization. Section 3449 and Section 5041 of the *Manual* both indicate that payments will be made for sterilization procedures. The CFPPD survey indicated that the Department *requires* the *referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Hawaii Medicaid program, family planning services are "Provided. Including contraceptive drugs and services, sterilization, fertility tests, and correction of infertility . . . Reimbursement to physicians on the basis of usual and customary charge, but not to exceed Hawaii Medical Association's relative value scale on a conversion factor of 5." The extent of utilization of the Medicaid program for family planning services is unknown. For additional information on Medicaid see Federal Law and Policies Section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Idaho

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Idaho.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Idaho has a statute regulating the sale and distribution of contraceptives and prophylactics. Idaho Code Ann. §§ 39-801 to 39-810 (1961). An exception in the statute provides that it does not apply to physicians and medical practitioners licensed in Idaho.

Under the statute, there are two kinds of licenses, wholesale and retail. A wholesale license may be granted to wholesale druggists and drug sundries jobbers, surgical supply houses or manufacturers of contraceptives and prophylactics. One holding such a license may dispose of these goods only to another licensee under this statute or to a physician or medical practitioner.

A retail license may be granted only to retail drug stores operated by or employing a registered pharmacist. Dispensation of contraceptives and prophylactics may be made only from the prescription counter and by a registered pharmacist.

Dispensation of these articles by vending machine or house to house or street solicitation is prohibited.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* The above mentioned statute also prohibits the display or advertising of contraceptives and prophylactics, with the exception that they may be advertised in medical and drug publications and in literature enclosed in or around the original package. Idaho Code Ann. §39-807 (1961).

Another Idaho statute makes it a felony to advertise any medicine or means for preventing conception or facilitating abortion or to offer one's services to assist in accomplishing such purposes. Idaho Code Ann. § 18-603 (1948).

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21 for males and 18 for females, but any male 18 or older and any female younger than 18 who has been married may enter into a contract. Idaho Code Ann. § 32-101 (1963).

Males of 21 and females of 18 are capable of con-

senting to marriage on their own. Males aged 18-21 and females 16-18 need written parental consent in order to be issued a marriage license. Females younger than 16 and males younger than 18 may be issued a marriage license only with written parental consent and a court order based upon a finding that the minor is "physically and/or mentally so far developed as to assume full marital and parental duties, and/or that it is to the best interest of society that the marriage be permitted." Idaho Code Ann. § 32-202 (1971 Cum. Supp.)

In *Cross v. Cross*, 110 Mont. 300, 102 P. 2d 829 (1940), a Montana court, interpreting Idaho law, held that the requirement of parental consent is applicable only to the issuance of a license and is simply directory to the clerk; the court said the lack of parental consent does not affect the validity of the marriage. (See also *Mays v. Folsom*, 143 F. Supp. 784 (1956) where the court held that under Idaho law the marriage of a 16-year-old female without parental consent was not void, though it could be annulled.)

A minor of 14 or older who may have come in contact with any infectious, contagious or communicable disease required to be reported to the local health officer may give consent to the furnishing of hospital, medical and surgical care related to the diagnosis or treatment of such disease without the necessity of parental consent. Chapter 107 (H.B. No. 91), 1971 Idaho Laws.

We have found no cases indicating whether Idaho courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies and where the minors are "emancipated"¹ or whether Idaho courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

The welfare department policy makes no reference to the requirement of parental consent but states that family planning services are to be made available to all persons "without regard to marital status, age, or parenthood." (See "Welfare Policy," "Eligibility," below). The health department does not require parental consent for contraceptive services to minors who are emancipated or have been married or pregnant. (See "Health Policy," "Eligibility," below).

Under Idaho law it is a crime for a person who has a child younger than 16 dependent on him or her for care or support, to wilfully omit, without lawful excuse, to furnish necessary medical attention for the child. Idaho Code Ann. § 18-401 (1971 Cum. Supp.)

Under Idaho's Child Protective Act, Idaho Code Ann. § 16-1624 ff. (1971 Cum. Supp.) the probate court has jurisdiction over any child (i.e., a person younger than 18) who is "neglected," defined to include any child who "lacks parental care necessary for his health, morals and well-being." § 16-1625. The court may take action necessary to protect the child's welfare including medical treatment under court order (See § 16-1639).

Footnote:

1. In *Embrie v. Embrie*, 85 Idaho 443, 380 P. 2d 216 (1963) the court, in discussing the concept of implied emancipation, said that "emancipation may also be implied by the parent's acquiescence in the child's working for others, receiving its pay therefor, and spending the money as it pleases." The court held that a boy who was almost 18, in good health, and employed by a service station six hours a day, five days a week while attending high school was "self-sustaining" in that he earned approximately \$40 a week, bought a car, made payments on its purchase price and was paying for its upkeep. (This case involved a divorced father's attempt to have a child support decree modified).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The Department of Health has a voluntary sterilization program which includes referrals for sterilization services for both males and females and the payment for sterilization services for males only (See Health Policy section, below).

The CFPPD survey indicates that the Department of Public Assistance *requires* referral and payment for sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it (See Welfare Policy section, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The written policy on family planning of the Idaho State Department of Health consists of a policy statement of the State Board of Health approving the Department's family planning program (unavailable), and *Guidelines for Determining Financial Eligibility* issued by the Crippled Children's Service of the Department's Child Health Division in December 1966.

2. *Eligibility:*¹ A letter from the Director of the Child Health Division to the Region X Program Officer of the National Center for Family Planning

Services, DHEW, dated December 1970, discusses Department policy on eligibility and patient fees: The Department of Health establishes financial and social eligibility requirements for family planning services. Under the Department's policy, all adults are eligible for family planning services. "Minors or teenagers must have parental consent unless they are in an emancipated status..." according to the letter cited above. However, according to the Department's policy as reported in the CFPPD survey, minors who have been pregnant or married are included among those who need not have parental consent. There is no minimum age requirement for eligible minors. The financial eligibility requirements which are set forth in the Guidelines cited above establish an approximate income ceiling of \$400-500 per month for a family of four. These are similar to federal standards for Crippled Children's Programs. There are no geographical eligibility requirements or patient fees established in health agency policy.

3. *Administration:*² The Maternal and Child Health Section has administrative responsibility for family planning services in the Department of Health. Professional and clerical staff assigned to family planning activities include: the acting MCH Director, 10-25 percent time; one controller, 10-25 percent time; one program coordinator, 10-25 percent time; and one secretary, 10-25 percent time. The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$17,825 of new MCH funds were allocated to the Department of Health in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$217,045. Of these funds, an estimated \$16,175 were spent for family planning services. The Department received a grant from the National Center for Family Planning Services, DHEW, for \$90,000 in FY 1971 of which the state matching contribution was \$30,000.

5. *Voluntary Sterilization:*⁴ The Department of Health has no written policy in regard to voluntary sterilization. However, the Department's voluntary sterilization program encompasses referrals for sterilization services for both males and females and the provision or purchase of sterilization services for males only. These services are intended for low-income persons.

Footnotes:

1. Unless otherwise indicated, information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
4. As reported in CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Idaho is contained in Sections 3060 and 3061 of the *Operating Policies and Procedures Manual* of the Department of Public Assistance. These revised sections were published on October 6, 1971 and implemented on November 1, 1971. Section 3061 states: "For those individuals whose needs are taken into account in the determination of the assistance payment, family planning services include information, referral, physician's services and such medications or prosthetic devices as may be prescribed by the physician as a part of family planning services." The policy contains no statement on the objectives of the family planning programs.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Public Assistance *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical family planning services for these eligible individuals.

The policy authorizes reimbursements to hospital outpatient clinics and private physicians. Health departments and voluntary agencies are not authorized to receive reimbursement. The Department reported that "Idaho Medical Services Bureaus establish 'usual and customary' fees regionally."² The Department has no contracts and/or other formal arrangement with providers of family planning services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance, as well as applicants and potential recipients of such assistance, are eligible for medical family planning services. Past recipients of such assistance, General Assistance recipients, and residents of low-income areas are eligible for referral services only.

The policy makes no reference to requirements for parental consent. According to Section 3060, family planning services are to be made available "without regard to marital status, age, or parenthood."

4. *Administration:*⁴ Responsibility for the administration of family planning program rests with the Division of Family and Children's Services. No staff are specifically assigned either full- or part-time to family planning. The Division's family planning activities include the training of local welfare staff and the development and distribution of public educational materials.

5. *Financing:*⁵ The Department of Public Assistance received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Public Assistance has no written policy on sterilization, but the CFPPD survey indicated that the Department *requires referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states under the Idaho Medicaid Program family planning services are "Provided. Limited to physician's services . . . Reimbursements on basis of usual and customary fees." The extent of the utilization of the Medicaid Program for family planning services is unknown. For additional information on Medicaid, see Federal Laws and Policies Section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Illinois

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* In June 1965, a resolution proposed by the Illinois Birth Control Commission was adopted by the Illinois legislature permitting referrals for family planning for all welfare mothers over 15 regardless of marital status. Other than this, there is no law establishing a state family planning program.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.¹

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority for some purposes, including the right to enter into valid contracts, has been reduced to 18. Public Act 77-1229, approved August 24, 1971. Eighteen-year-olds and married and pregnant minors may consent to all medical care. Ill. Ann. Stat. ch. 91, § 18.1 (Smith-Hurd 1972 Cum. Supp.)

There is also a statute authorizing licensed physicians to provide birth control services and information "to any minor: 1.) who is married; or 2.) who is a parent; or 3.) who is pregnant; or 4.) who has the consent of his parent or legal guardian; or 5.) as to whom the failure to provide such services would create a serious health hazard; or 6.) who is referred for such services by a physician, clergyman, or a planned parenthood agency." Ill. Ann. Stat. ch. 91, § 18.7 (Smith-Hurd 1972 Cum. Supp.)

A hospital or physician may render emergency treatment or first aid to a minor if, in the sole opinion of the physician or hospital, the obtaining of consent is not feasible without adversely affecting the condition of the minor's health. Ill. Ann. Stat. ch. 91, § 18.3 (Smith-Hurd 1972 Cum. Supp.)

Illinois also has a statute authorizing a minor 12 years of age or older who may have come into contact with any venereal disease to consent to medical care related to the diagnosis or treatment of such disease. Ill. Ann. Stat. ch. 91, § 18.4 (Smith-Hurd 1972 Cum. Supp.) Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease may, but shall not be obligated to, inform the parent, parents or guardian of any such minor as to the treatment given

or needed. Ill. Ann. Stat. ch. 91, § 18.5 (Smith-Hurd 1972 Cum. Supp.)

The health department recommends that all minors be considered eligible for services without parental consent (See Health Policy, Eligibility, below); and there are no restrictions on services to minors in welfare department policy, which provides that family planning services be made "available without regard to sex, marital status, age or parenthood." (See Welfare Policy, Eligibility, below.)

Footnote:

1. An older statute, Ill. Rev. Stat. ch. 38, § 468 (1934), prohibited the distribution or sale of any "article of indecent or immoral use." Several cases arose under this statute both applying it and construing it. The court in *Lanteen Laboratories, Inc. v. Clark*, 294 Ill. App. 81, 13 N.E. 2d 678 (1938) said that the indiscriminate sale of contraceptives through drug stores to both married and unmarried persons was the sale of an "article of indecent or immoral use" within the purview of §468 and was against public policy. The *Lanteen* case involved a suit to enforce a contract concerning the development of a contraceptive device. The court, raising the issue on its own initiative said the contract was against public policy and thus unenforceable; public policy was expressed in the federal Comstock statutes, for example, and in the fact that half the states at that time had their own "little Comstock" laws. Though § 468 did not specifically refer to contraception, the court felt that the Comstock statutes' language placed contraceptives within the class of articles for "indecent or immoral use."

In *Ostrowsky v. Berg*, 337 Ill. App. 422, 86 N.E. 2d 546 (1949), the court allowed suit on a contract involving the sale of "prophylactics" as opposed to "contraceptives." Such a contract involved the sale of articles for the prevention of disease (prophylactics) and not the prevention of conception (contraceptives) and therefore was not against public policy and not within the purview of § 468. This Section was repealed and superseded in 1961 and again in 1965, by Ill. Rev. Stat. ch. 38, § 11-20 concerning obscenity. The phrases concerning "articles for indecent or immoral use" have been deleted so that courts can no longer include contraceptives within the class of articles covered by the statute.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Doerr v. Villate, 74 Ill. App. 2d 332, 220 N.E. 2d 767 (1966), was an action for damages against a physician who performed a sterilization operation on plaintiff's husband after plaintiff had given birth to two retarded children. After the surgery, plaintiff

and her husband resumed sexual relations and as a result, a child was born who was both retarded and physically deformed. The court held that the action was not barred by the two-year statute of limitations applicable to actions for personal injuries. The court assumed that there was no question about the legality of voluntary sterilization.

In an early case, *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906), a surgeon was held liable for trespass to the person of a woman whose uterus he removed for medical reasons without obtaining her consent or that of her husband. The woman suffered from mental illness, and two years after the surgery was adjudged insane. The court questioned whether under these circumstances the husband had authority to consent for his wife; it seems likely that, had the wife been sane, her consent alone would have been required.

We have seen that in June, 1965, the Illinois legislature adopted a resolution permitting referrals for family planning of all welfare mothers over 15 (See Laws Establishing Family Planning Programs, above). In this connection, the CFPPD survey indicates that the Department of Public Aid *requires* referral and payment for sterilization procedures by the local welfare agencies for eligible welfare recipients wishing them. (See the Welfare Policy section, below.)

Minors: We have seen that Illinois authorizes birth control services for broad categories of minors without parental consent. (See Laws Relating to Contraceptive Services to Minors, above.) The statute does not specifically refer to voluntary sterilization and, in the absence of case law, it is not clear whether or not voluntary sterilization is included. The Attorney General of Virginia expressed an opinion (since rendered moot by enactment of a recent law) that a similar statute in that state included voluntary sterilization as a "means of birth control" and parental consent was therefore not required. (Letter from Attorney General Andrew P. Miller to the Hon. Charles L. McCormick, III, Commonwealth's Attorney for Halifax County and City of South Boston, Oct. 1971, See Virginia profile.) In any event, it appears that consent to voluntary sterilization may validly be given by any person 18 years of age or older or by a married person who is a minor or a pregnant woman who is a minor, under Ill. Ann. Stat. ch. 91 § 18.1 (Smith-Hurd 1972 Cum. Supp.).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current written policy on family planning of the Illinois Department of Public Health consists of a *Policy Statement on Family Planning*, dated June 1968, and a memorandum, "Subject: Family Planning Grants

for Fiscal Year 1972," issued by the Division of Family Health, dated March 18, 1971, containing guidelines for family planning grants. The 1968 *Policy Statement* states in part that "assistance in family planning should be made available to all who wish it in accordance with their individual desires and beliefs," that family planning "should be provided only by physicians or through programs conducted with support of physicians. . . ." and that the Department of Health "will give consultation and cooperate with local health agencies as well as private health agencies" in developing "public and private educational services . . ." in family planning and will "support medical programs and referral services for those groups which would not otherwise be able to avail themselves of professional services by a private practitioner."

The guidelines for family planning grants included in the memorandum cited above outline the requirements and procedures for making grant applications in FY 1972. Beginning in that fiscal year, both local health departments and other qualified agencies will be eligible applicants. Program content will be judged by a review committee. "Coordination with other health service organizations and integration of family planning into total health services will be a primary consideration of the review committee," according to the guidelines, and "the applicant agency or organization must have the administrative ability and structure to insure responsibility for use of federal funds." The guidelines indicate the necessary features of a grant application, including objectives of the program, a description of the population to be served, a description of the services to be provided, and further details concerning the components of a completed application. The guidelines also set forth standards for program operation.

2. *Eligibility:*¹ All financial, social and geographical eligibility requirements, as well as patient fees, are determined locally; however, the Department of Public Health recommends that all categories of adults and all minors, without parental consent, be considered eligible for family planning services. The Policy Statement cited above states that "It is the position of the Illinois Department of Public Health that assistance in family planning should be made available to all who wish it in accordance with their individual desires and beliefs."

3. *Administration:*² The Division of Family Health has administrative responsibility for family planning in the Department of Public Health. Professional staff assigned to family planning activities include: one chief public health physician, less than 10 percent time; one MCH physician, less than 10 percent time; four MCH consultant nurses, 10-25 percent time; and one MCH administrator, less than 10 per-

cent time. The state health agency performs the following functions in support of family planning activities: consultation; central data processing; and grants or contracts to local family planning programs for supportive services.

4. *Financing*:³ \$271,296 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds in FY 1971 was \$1,353,163. An estimated \$71,704 of these funds were spent for family planning. The Department of Public Health received no specific appropriation for family planning from the state legislature and no other Department funds were used for family planning.

5. *Voluntary Sterilization*: The Department of Public Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Illinois is contained in Section 5104.5, dated March 1970, and in Section 6126, dated September 1971, of the *Manual of Illinois Department of Public Aid*. Section 6126 states that "Family planning services must be offered and provided to those individuals wishing such services, specifically including medical contraceptive services (diagnosis, treatment, supplies and follow-up), social services and educational services." Section 5104.5 specifies that "The fee for the first visit to the physician includes pelvic examination and a cervical smear (Papanicolaou Test) when indicated." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Aid *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, voluntary agencies and private physicians. Health departments are not authorized to receive reimbursement. There is no single, stand-

ard statewide reimbursement rate for medical family planning procedures.² The Department has no contracts or other formal arrangements with providers of services for the provision of family planning services. However, the Department reported that "working arrangements [have been] developed, but not formalized by contract."

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. However, the Department reported that "former and potential recipients who receive family planning services through the Illinois Department of Children and Family Services are eligible for referral and payment." General Assistance recipients are eligible for medical family planning services.

There are no additional limitations which affect the provision of service to adults or minors. Section 5104.5 provides that family planning "services are available without regard to sex, marital status, age or parenthood."

4. *Administration*:⁴ The Division of Program Development and the Division of Medical Services share administrative responsibility for the welfare family planning program. No staff are specifically assigned either full- or part-time to family planning. Family planning activities of these divisions include the training of local welfare staff and "preparation and distribution of informational pamphlets."

5. *Financing*:⁵ The Department of Public Aid received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Aid has no written policy on sterilization but the CFPPD survey indicated that the Department *requires referral* for and the *purchase* of voluntary sterilization procedures by local welfare agencies for eligible public assistance recipients wishing them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Illinois Medicaid program, family planning services are "Provided. No limitations. . . . Payments to physicians and organized facilities. Reimbursement on basis of usual and customary charges, if reasonable." The 1970 City University of New York study reported that \$67,923 was expended for medical family planning services and \$259,389 for drugs and devices by the Illinois Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures were \$193,423 and \$335,054 respectively. For additional information on Medicaid see the Federal Law and Policy Section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Indiana

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Indiana.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* In 1963, Indiana deleted from its law provisions concerning the sale and distribution of articles for the prevention of conception.¹ There is now no state law specifically restricting or regulating the distribution or sale of contraceptive drugs or appliances.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Indiana has a statute which prohibits advertising or publishing any account or description of a drug or apparatus for preventing conception. The statute also prohibits selling or giving away any newspaper, book or pamphlet containing such an advertisement or description. Ind. Ann. Stat. § 10-2806 (1956). Indiana's Health Agency policy, however, is to provide information and services to the public on family planning (See Health Policy, below). We have found no record of any case where these provisions of law were invoked although the distribution of published material to the media and to the public is the same in Indiana as elsewhere.²

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. Ind. Ann. Stat. § 2-4701 (1968); *Hurd v. Ball*, 128 Ind. App. 278, 143 N.E. 2d 458 (1957), transfer denied, 237 Ind. 665, 148 N.E. 2d 194 (1958). However, females may marry at 18 without parental consent. Ind. Ann. Stat. § 44-202 (1965).

By statute in Indiana, any person younger than 21 who has, suspects he or she has, or who has been exposed to any venereal disease is competent to give consent for medical treatment. Ind. Ann. Stat. § 35-4411 (Cum. Supp. 1971).

Indiana has a statute authorizing "emancipated" minors and married minors living with their spouses to give effective consent to medical and surgical care. Ind. Ann. Stat. § 35-4409 (1969). Although the statute does not define "emancipated," there are numerous judicial decisions in Indiana defining emancipation for various purposes.

A number of cases deal with the question of whether a minor is emancipated in order to determine whether the parent or the child (or his estate) is entitled to damages for personal injuries to or death of the minor. Emancipation is never presumed but must be established. It may, however, be shown by express agreement or by circumstantial evidence or the conduct of parent and child. *Allen v. Arthur*, 139 Ind. App. 460, 220 N.E. 2d 658 (1966).

It is sufficient for an administrator suing on behalf of a deceased minor's estate to allege that the minor had for several years been working, collecting his own wages and handling his own financial affairs. *Wabash R. Co. v. McDoniels*, 183 Ind. 104, 107 N.E. 291 (1914); *Public Service Co. of Indiana v. Tackett*, 113 Ind. App. 307, 47 N.E. 2d 851 (1943). A jury could find that a 16-year-old girl was emancipated even though she lived at home where she had left school and was working and collecting her own wages. *Penn. R. Co. v. Patesel*, 118 Ind. App. 233, 76 N.E. 2d 595 (1948). A minor in the armed forces was held emancipated while so serving, *Wallace v. Woods*, 271 N.E. 2d 487 (Ind. App. 1971).

Suits by minors to recover compensation for services rendered have been permitted where the minor went to live in someone else's home (*Hensley v. Hilton*, 191 Ind. 309, 131 N.E. 38 (1921); *Surface v. Dorell*, 115 Ind. App. 244, 57 N.E. 2d 66 (1944)) and where the minor lived at home but was permitted to keep his own earnings. *Haugh, Ketcham & Co. Iron Works v. Duncan*, 2 Ind. App. 264, 28 N.E. 334 (1891). In a suit by a minor to recover payments made on a piano after avoiding the contract to purchase the piano, the court held that by allowing his daughter to use her own earnings to make payments on the piano and by bringing the lawsuit as her "next friend," the father had relinquished his right to her earnings. *Story & Clark Piano Co. v. Davy*, 68 Ind. App. 150, 119 N.E. 177 (1918)).

In other cases, fathers have claimed to be relieved of support obligations under a divorce decree on the ground that the child is emancipated. A finding that a son was not emancipated for this purpose was sustained where the son had been graduated from high school and was attending college with his father's approval. *Stitle v. Stitle*, 245, Ind. 168, 197 N.E. 2d 174 (1964). Where a son had enlisted in the Army with

his parents' consent he was held to be emancipated for the term of his service, relieving the father of support obligations. *Corbridge v. Corbridge*, 230 Ind. 201, 102 N.E. 2d 764 (1952). (But see *Carson v. Carson*, 120 Ind. App. 1, 89 N.E. 2d 555 (1950), reaching a different result where the husband had contracted to make payments until the son reached 21.)

In an action to set aside a deed as fraudulent, the plaintiff argued that there was no consideration for the deed, which was made by a young man to a woman who cared for him in her home from the time his mother died when he was 11 years old. The father had asked the woman to keep the boy. The court held that there was consideration for the deed because the boy was emancipated by abandonment. *Robinson v. Hathaway*, 150 Ind. 679, 50 N.E. 883 (1898).

Section 35-4409 of the Indiana statutes, which authorizes emancipated minors and married minors living with their spouses to consent to medical and surgical care, was enacted in 1965. In 1961, Indiana had enacted a more general law dealing with consent to medical or surgical treatment of a person "incompetent to give such consent by reason of minority, insanity, mental illness, imbecility, idiocy, senility, habitual drunkenness or drug addiction." Ind. Ann. Stat. § 35-4407 (1969). That statute provides that consent may be given by the following persons:

(a) If the patient is an unmarried unemancipated minor, by one [1] parent having custody of such minor, Provided, That if there is no such parent, by the legal guardian of the minor, and further provided that if the patient is a neglected child, by the agency of which the child has been made a ward of the juvenile court.

(b) If the patient is an emancipated minor, by the patient; Provided further, That if such minor be married, then his or her spouse shall join in such consent.

Although there are no reported cases on this subject, it would seem that the later statute (Section 35-4409) in effect repeals the spousal consent requirement imposed on married minors by Section 35-4407.

Section 35-4408, also enacted in 1961, provides:

The methods of consent set out in this act [§§ 35-4407, 35-4408] are not to be construed so as to exclude other methods of consent otherwise lawful nor to require consent in an emergency.

Again, there are no reported cases construing this statute. It may be inferred from the statutory language, however, that physicians may treat minors in an emergency without parental consent. An opinion of the Indiana Attorney General states that consent is implied when an immediate operation is necessary to preserve life or to prevent further aggravated physical injury to the minor patient. Official Opinion No. 52, Opinions of the Attorney General of Indiana (1948) p. 289.

No cases were found indicating whether Indiana courts would accept the "mature minor doctrine" described in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors. However, the Indiana Attorney General has stated:

In some instances, even though the exigencies of a situation do not demand an immediate operation, i.e. where there is no imminent peril to life, a surgeon may operate a mature youth [sic], if his consent has been given, and ostensibly the parent has consented, although no express consent of the parent has been granted, and no liability will result. Official Opinion No. 52, *supra* at 290-291.

The Attorney General cited the case of *Bakker v. Welsh* (discussed in the Michigan state profile) for the "mature minor doctrine."

We have seen that consent to medical care for a neglected child may be given "by the agency of which a child has been made a ward of the juvenile court." Section 35-4407 (a), *supra*. Indiana's neglect statute includes in its definition of criminal neglect of a child "willfully failing to provide . . . medical attendance or surgical treatment." Ind. Ann. Stat. § 10-813 (1956).

Footnotes:

1. Ind. Ann. Stat. §§ 10-2803 and 10-2804 (1956).
2. It appears that at least some aspects of this statute, if applied, would be vulnerable on First Amendment freedom of the press grounds.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Indiana has a statute providing for the compulsory sterilization of inmates of hospitals and other institutions afflicted with certain incurable conditions. This statute contains the following provision:

Nothing in this act (Sections 22-1601-22-1606) shall be construed so as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this state, by a physician or surgeon licensed by this state, which treatment may incidentally involve the nullification or destruction of the reproductive functions: Provided, that such treatment shall be that which is recognized as legal and approved after due process of law. Ind. Ann. Stat. § 22-1606 (1964).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed on a person who is otherwise subject to the provisions of the compulsory sterilization law, the procedures prescribed in that law need not be followed although the operation may result in sterilization of the patient.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current health agency policy on family planning consists of a

policy statement entitled *Indiana State Board of Health Policy Statement on Family Planning Programs*, adopted by the Executive Board of the Indiana State Board of Health, November 9, 1966. It states that "it shall be the policy of the Indiana State Board of Health to provide information and services to professional persons rendering maternity care and to the public on family planning. The provision of information and services shall be in keeping with the attitudes and receptiveness of a local community . . ." Such services shall be voluntary. Family planning activities to be carried out by the Indiana State Board of Health may include public information, inservice training for professional persons working in maternity programs, and, "where indicated, the Indiana State Board of Health may assist local agencies in financing family planning services," according to the statement. The Board of Health shall also "encourage the development throughout the state of private and public resources for family planning as a part of overall maternity care."

2. *Eligibility*:¹ Financial, social and geographical eligibility requirements for family planning services, as well as patient fees, are determined solely by local agencies. The State Board of Health "advises that all individuals who may want and need family planning services [should] have access to them."

3. *Administration*:² The Division of Maternal and Child Health has administrative responsibility for family planning services in the State Board of Health. Professional staff assigned to family planning activities include: the Director of Maternal and Child Health, 10-25 percent time; seven nursing consultants, 10-25 percent time; and two health educators, less than 10 percent time. The Board of Health performs the following functions in support of family planning activities: consultation, training, development and distribution of public educational materials, and grants or contracts to local family planning programs.

4. *Financing*:³ \$222,464 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. Of these funds \$107,000, or 48 percent were obligated for family planning activities. According to the Board of Health's MCH Division, FY 1971 earmarked MCH funds were received too late in the fiscal year to utilize all of the funds. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$1,035,547. An estimated \$37,000 of these funds were spent for family planning. The Board of Health received no specific appropriation for family planning from the state legislature. No other state funds were utilized by the Board of Health for family planning services.

5. *Voluntary Sterilization*: The Board of Health

has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Indiana is contained in *General Administrative Bulletin No. 66* of the Department of Public Welfare and in Volume III, Section H of the *Families and Children Manual*. The 18-page *Bulletin*, dated April 20, 1970, covers state and county family planning policies and procedures in detail, and also includes basic medical standards for family planning services. Section VII of the *Bulletin* includes the following:

Statistics . . . show that the population growth of this country since World War II has resulted more from the choice of the affluent to have children than from the high fertility of the poor. As county departments interpret the goals of their family planning services, therefore, the emphasis will be on the goal of helping to alleviate the burden which high fertility imposes on the poor, and not on a concern for the general population problem.

According to Section II of the *Bulletin*, "The purpose of the (family planning) requirement is to promote services which will improve the health of the family, reduce the incidence of mental retardation or other handicapping conditions caused by complications of child-bearing, and reduce infant and maternal mortality."

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning resources. Local welfare agencies are *authorized* but not required to *purchase* family planning services for eligible public assistance recipients.

The policy, therefore, permits the purchase of medical family planning services and reimbursement can be made to hospital outpatient clinics, voluntary agencies, and private physicians. Health departments, however, are not authorized to receive reimbursement under the policy. Section V of the *Bulletin* states: "The county department is responsible for arranging for payment for family planning services for county department clients who cannot purchase their own services." The Department reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures but that Mutual Medical Insurance, Inc., the fiscal

agent, has data on current rates.² The Department has no contracts and/or other formal arrangements with providers of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as applicants and potential recipients of such assistance and residents of low-income areas are eligible for medical family planning services. Past recipients of such assistance are eligible for referral services only. There is no General Assistance program which is administered by the state or county departments of public welfare.

There are no additional limitations that affect the provision of services to adults. Parental consent is required for the provision of services to all minors except those that are married or emancipated. Section X of the *Bulletin* provides that "in general, the county department policy should be to offer family planning services to unmarried teenagers who have a need for such in cooperation with their parents so long as they are unemancipated."

4. *Administration:*⁴ Responsibility for administration of the family planning program rests with the Children's Division of the State Department of Public Welfare. Six of the Division's consultants spend

less than 10 percent of their time on family planning activities. Family planning activities of the Division include the training of local welfare staff and the development of policy and program materials.

5. *Financing:*⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Public Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Indiana Medicaid program, family planning services are "Provided. . . . Reimbursement on basis of reasonable charges." The extent of utilization of the Medicaid program for family planning services is unknown. For additional information on Medicaid, see Federal Laws and Policies Section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Iowa

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:*

In 1965, the Iowa legislature authorized the Social Welfare Department to provide, pay for, and offer family planning and birth control services to every parent or married person who is a public assistance recipient "where it deems necessary." Iowa Code § 234.21 (1966). These services may include interviews, distribution of literature, referrals to physicians for consultation, examination, tests, medical treatment and prescriptions, and to the extent prescribed, distribution of rhythm charts, drugs and devices for birth control and family planning. § 234.22. However, those persons to whom services are rendered may be charged a fee sufficient to cover the costs of services. § 234.23. Any person may refuse to accept family planning and birth control services without jeopardizing his or her right to receive public assistance and other public benefits. § 234.24.

Where the public assistance recipient does not speak or read English, the statute requires that family planning services not be given unless the interview and literature are in a language which the recipient understands. § 234.25.

The statute also provides that the provisions of Chapter 725, relating to obscenity, shall not apply to the services provided under §§ 234.21 to 234.27. (See sections 2 and 3 below for discussion of Chapter 725.)

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:*

Iowa has a statute condemning obscene books and articles, among which are included contraceptives. Iowa Code § 725.5 (1966). This statute prohibits the selling, offering for sale or having in possession with intent to sell or give away medicines or articles for preventing conception. An exception in the statute is made for regular practitioners of medicine and druggists in their regular business, for teaching in regular medical colleges, and for the publication and use of standard medical books. Iowa Code § 725.10 (1966).

In 1934, the Attorney General stated that the sale of contraceptives by druggists is permissible as it comes within the exception stated in Section 725.10. Op. Atty. Gen. 1934, p. 690.

According to a 1971 Attorney General's opinion interpreting Section 725.5, prophylactics as well as

contraceptives are within the scope of the section. The Attorney General stated that the sale or offer of prophylactics by others than doctors or druggists in the practice of their regular profession is prohibited because, although prophylactics may have the dual purpose of preventing conception and preventing venereal disease, they are "designed or intended for . . . preventing conception," and therefore come within the purview of Section 725.5. Op. Atty. Gen. February 15, 1971, #71-2-39.

The constitutionality of Section 725.5 was challenged in *State of Iowa v. Social Hygiene, Inc.*, 261 Iowa 914, 156 N.W. 2d 288 (1968). In this case the defendant was charged with violating the statute by selling articles designed or intended to prevent conception by vending machine. The defendant claimed that the statute was unconstitutional because its title, "Obscene literature—articles for immoral use," did not mention conception, and under Iowa's constitution, every act must "embrace but one subject." The Supreme Court of Iowa held that the title was broad enough to embrace conception and that therefore the statute was not unconstitutional. (For further discussion of §§ 725.5 and 725.6, see Op. Atty. Gen. 1970 #70-3-35, below).

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:*

Section 725.5 (discussed above) also prohibits the advertising of medicines or articles for preventing conception, and the writing of any notice, letter, book or pamphlet with information on how these proscribed articles can be obtained or purchased. Section 725.6 prohibits the circulation or mailing of matter referred to in Section 725.5.

An exception in the statute is made for regular practitioners of medicine and druggists in their regular business, for teaching in regular medical colleges, and for the publication and use of standard medical books. Iowa Code § 725.10 (1966). In a case arising in 1939, the Iowa Supreme Court held that since druggists were excepted from the operation of Section 725.6, a druggist could deliver a number of pamphlets entitled "Birth Control," advertising a contraceptive device, to a third person for purposes of conveying the pamphlets to the houses in a city. *State v. Chenoweth*, 226 Iowa 217, 284 N.W. 110 (1939).

The question of who can deliver literature pertaining to birth control arose again in 1970 and was referred to the Attorney General for a ruling. It was the Attorney General's opinion that literature pertaining to birth control is not an "article or thing designed or intended for . . . preventing conception" within the meaning of the statute, and that therefore such literature may be circulated freely, provided it is not worded in foul or obscene language, and that it does not constitute an actual advertisement for medicines, articles or things for preventing conception—apparently trade-branded items sold at particular stores. In the Attorney General's words, the prohibition extends to advertisements urging: "buy Such and Such contraceptives at So and So's Drug Store." Op. Atty. Gen. 1970, #70-3-35.

4. *Laws Relating to Contraceptive Services to Minors*: "The period of minority extends to the age of twenty-one years, but all minors attain their majority by marriage; and females, after reaching the age of eighteen years, may make valid contracts for marriage the same as adults." Iowa Code Ann. § 599.1 (1950).

A marriage between a male of 18 and a female of 16 years of age is valid. If either of the parties to the marriage is underage, the marriage may still be valid if the underage party chooses not to annul it within six months after attaining the required age. Iowa Code Ann. § 595.2 (1972 Cum. Supp.).¹ The common law rule which set the minimum age of marriage at 14 for males and 12 for females has not been abrogated in Iowa so that a marriage where one of the parties is above these ages is valid (but is subject to annulment under § 595.2). *Boehm v. Rohlf*s, 224 Iowa 226, 276 N.W. 105 (1936); *Goodwin v. Thompson*, 2 G. Green 329 (1849). Males younger than 21 and females younger than 18 need parental consent in order to be granted a marriage license. Iowa Code Ann. § 595.3 (2) (1972 Cum. Supp.).²

A minor of 16 or more can consent to diagnosis and treatment of venereal disease. The physician must notify the minor's parents that the minor has venereal disease when it appears that the minor might communicate the disease to members of his family. Iowa Code Ann. § 140.9 (1971 Cum. Supp.)

In an emergency which endangers the life or health of the minor patient, a physician may do "what the occasion demands within the usual practice" among physicians in that locality without parental consent, where a reasonable effort to reach the parents has been made. *Jackovich v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931).

Although we have found no cases or Attorney General opinions on the question of an emancipated minor consenting to his or her own medical care, Iowa courts do view emancipation as an ex-

tinguishment of parental rights and duties (see cases discussed below), and may be presumed to follow the general pattern of permitting an emancipated minor to consent to his or her own medical care without the necessity of parental consent.

Some examples of how the Iowa courts view emancipation follow:

It has been held that a minor who is emancipated does not by that fact alone attain his majority. *Clay County v. Palo Alto County*, 82 Iowa 626, 48 N.W. 1053 (1891).

In *Everett v. Sherfey*, 1 Iowa 356 (1855), the court, stating that emancipation need not be evidenced by any formal act and may be proven like any other fact, held that a 17-year-old who left his father's home after a misunderstanding and lived and worked on his own, had been emancipated. The evidence showed that the father did not exercise proper and necessary control and authority over his son, and moreover had published in the newspaper a statement forewarning persons from giving his son credit on his account since he wouldn't pay his son's debts. (The father was thus prevented from suing his son's employer for the son's wages.) The court also stated that emancipation may be revoked at any time during the child's minority. See *Wolcott v. Rickey*, 22 Iowa 171 (1867); *Vaupel v. Bel-lach*, 261 Iowa 376, 154 N.W. 2d 149 (1967).

It has been held that a mutual understanding is sufficient to constitute emancipation and that the understanding may arise by implication from the acts and conduct of the parties. *Kubic v. Zemke*, 105 Iowa 269, 74 N.W. 748 (1898). Parental action or nonaction inconsistent with the parent's rights and obligations to his or her child also shows emancipation. Thus, where a father deserted his child when the child was nine years old the child was held to be emancipated, and the father could not collect damages for loss of services of his son when the boy was killed at age 13. *Lipovac v. Iowa Railway and Light Co.*, 202 Iowa 517, 210 N.W. 573 (1926).

Where a parent allows his minor son to work and collect and spend his own wages, the fact that the minor still lives at home and helps his father somewhat with his work, does not mean that the son is not emancipated. *Bristor v. Chicago & N.W. Ry. Co.*, 128 Iowa 479, 104 N.W. 487 (1905).

In *Jacobs v. Jacobs*, 104 N.W. 489 (1905), a minor son who lived at home and whose clothing was provided by his parents, was permitted by his father to carry on a business of selling papers from which he earned more than \$25,000 over the years. The minor, with his father's consent, turned the money over to his mother who invested the money in her son's name. The court held these facts sufficient to constitute emancipation of the minor since

the father had voluntarily surrendered his rights to the son's earnings.

In *Porter v. Powell*, 79 Iowa 151, 44 N.W. 295 (1890), a 14-year-old minor who, with her father's consent, lived and worked away from home, controlled her own wages and bought her own clothing, was held emancipated. However, when the girl was 17 she became ill with typhoid fever and contracted, without her father's knowledge or consent, for medical services. The doctor subsequently sued her father for payment. The court, in allowing the doctor's claim, held that the minor was at most partially emancipated; the father had a right to require his daughter to return home at any time and the daughter had a right to return at any time. The court discussed partial emancipation, stating:

To free a child, for all the period of minority, from the care, custody, control and service would be a general emancipation; but to free him from only a part of the period of minority, or from only a part of the parent's rights, would be limited. The parent . . . may surely release from either without waiving his right to the other. . . .

In *Cooper v. McNamara*, 92 Iowa 243, 60 N.W. 522 (1894), the court held that where an 18-year-old minor had available a home with his parent and where he was under his parent's control, he was not emancipated despite the fact that he had lived and worked away from home for several months. (The court stated that a parent's liability for a minor child's necessities continues since, in the absence of evidence to the contrary, the presumption is that the minor is subject to the control of the parent even when away from home.)

Other cases have held that the fact that a minor child is outside the home and spending his own money does not in itself demonstrate emancipation. *Vaupel v. Bellach*, *supra*; *Brandhorst v. Galloway*, 231 Iowa 436, 1 N.W. 2d 651 (1942) (Workmen's Compensation case). In the *Vaupel* case, a 19-year-old minor was living at home at the time in question; his mother was furnishing him room, board and laundry services for which he paid nothing. Previously he had worked outside the home and for several months had even lived away from home. During this time he had spent his money as his own. The court found no evidence of emancipation by voluntary act of the mother and held that he was not therefore, emancipated. (This case involved an auto accident where the son was driving and the mother was injured.)

In *Gerk v. Gerk*, 259 Iowa 293, 144 N.W. 2d 104 (1966), an 18-year-old lived with his mother, and was attending a technician's training school where he earned \$25 per week which he was saving for his future education; he was held not to be emancipated, so that his father was still liable for his support.³

We have found no cases indicating whether Iowa courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

An Iowa statute authorizes the state department of social welfare to provide family planning and birth control services to "every parent or married person who is a public assistance recipient." (See "Laws Establishing Family Planning Programs," above). This provision includes within its scope minor unwed mothers living at home. In the absence of case law, it is unclear whether the statute dispenses with the requirement of parental consent for such minors. However, the welfare department does not require parental consent for contraceptive services though regarding such consent as "desirable except for married minors and minors with at least one out-of-wedlock child."⁴ (See "Welfare Policy," "Eligibility," below).

A child adjudicated "neglected" comes under the jurisdiction of the juvenile court, and the court may order medical examination and treatment of the child. Iowa Code Ann. § 232.13 (1969). Under Iowa law, a "neglected child" is one "who is without proper parental care because of the faults or habits of his parents, guardian, or other custodian," or "who is living under conditions injurious to his mental or physical health or welfare." § 232.2 (15).

Iowa, in its provisions for medical care for indigent persons, provides that "no minor . . . shall be treated for any malady . . . except such as is reasonably well described in the order of the court or the report of the examining physician, unless permission for such treatment is provided for in the order of the court or is granted by his parents or guardian, but the physician in charge may administer such treatment or perform such surgical operations as are usually required in cases of emergency." Iowa Code Ann. § 255.22 (1969).

It is a crime for a parent to "wantonly neglect" to care for or supervise his or her minor child younger than 18 years of age. Iowa Code Ann. § 731A.1 (1950). "Wanton neglect" is "wilful neglect of such a nature, arising under circumstances as a parent of ordinary intelligence actuated by normal and natural concern for the welfare of the child would not permit or be a party to." Iowa Code Ann. § 731A.2 (1972 Cum. Supp.)

Footnotes:

1. The district court may authorize the issuance of a marriage license to applicants, one or both of whom are underage, when the female is pregnant or has given birth to a child which is still in her custody. § 595.2. Under this provision, parental consent to the issuance of a marriage license is not required. Op. Atty. Gen. Dec. 22, 1964. The Attorney General has stated that where both parties were 18 and the female was pregnant, the conditions of § 595.2 were not met and the district court therefore

could not order the issuance of a marriage license. Op. Atty. Gen. Apr. 22, 1970.

2. The Attorney General has stated that the consent of both parents is necessary unless the parents are divorced. Op. Atty. Gen. Jan. 15, 1970.
3. The incarceration of a minor child in a state hospital for the insane without his father's consent is not an emancipation of the child. *Guthrie County v. Conrad*, 110 N.W. 454 (1907).
4. There appears to be a confusion of terminology here because majority is automatically attained with marriage in Iowa.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

An Iowa Attorney General's opinion states that a physician may perform a sterilization operation upon a competent consenting adult. 1932 Op. Atty. Gen. Iowa 35.

An Iowa statute authorizes the state department of social welfare to provide family planning and birth control services to every parent or married person who is a public assistance recipient (See *Laws Establishing Family Planning Programs*, above). It is not clear whether "family planning and birth control services" include voluntary sterilization. However, the CFPPD survey indicates that the Department of Social Services requires referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients wishing them. (See Welfare Policy Section, below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: There is no official written state health agency policy on family planning in Iowa. The only available source of written policy is contained in a letter from the Chief of General Health Services to the Region VI Program Management Officer of the National Center for Family Planning Services, DHEW, dated November 20, 1970. The letter says in part: "The policy of the State Health Department is to promote and subsidize family planning services in order to make such services available to all citizens of the state who need them. We assure the citizens that family planning will be voluntary, that there will be several methods made available so that individuals can choose in accordance with their beliefs and consciences, that there will be no coercion and that there is proper medical supervision."

2. *Eligibility*: Financial, social and geographical eligibility requirements as well as patient fees are determined by local health agencies. According to the letter cited above, "There are no income require-

ments imposed by the State Department of Health for receiving services. Other state agencies and local agencies do in some cases have income eligibility requirements or guidelines. People may be referred to family planning agencies from any source including self-referral. There are no requirements with respect to marital status or parity. There is no cost to the patient in programs administered by the Department. Eligibility requirements do not differ from county to county . . . Requirements regarding minors is [sic] a policy decision of the Board of Directors of the agency operating the family planning clinic. In those few instances where contraceptive medicines or devices are purchased directly by the Iowa State Department of Health and provided for use in family planning clinics, they are not dispensed to unmarried minors without written parental or guardian consent."

The statement that "eligibility requirements do not differ from county to county" apparently should be interpreted to mean that the Department itself does not discriminate among counties in recommending policies on family planning. It is likely that various county agencies, having each made policy decisions on eligibility requirements independently, have developed somewhat differing requirements.

3. *Administration*:¹ The Division of Maternal and Child Health, General Health Services has administrative responsibility for family planning services in the Iowa State Department of Health. Professional staff assigned to family planning activities include: the MCH Director, 25-50 percent time; one nurse consultant, 10 percent time; and one family planning specialist, full-time. The Department performs the following functions in support of family planning activities: consultation, development and distribution of public educational materials, and grants or contracts to local family planning programs for support of services.

4. *Financing*:² \$114,358 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$576,764. An estimated \$129,106 of these funds were spent for family planning. The State Department of Health received no specific appropriation for family planning from the state legislature. No other state funds were utilized by the Department for family planning services.

5. *Voluntary Sterilization*:³ The State Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information contained in this

section was reported by the state health agency in the CFPPD survey.

2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocation of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
3. As reported in CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Iowa family planning policy is contained in Chapter VIII-11 of the *Employees' Manual* of the Iowa Department of Social Services, dated October 28, 1969. An additional policy statement is contained in a September 20, 1965 memorandum from the Department of Social Welfare to members of county medical committees. The 1969 policy states that "It is the policy of this Department to support in every way possible, the concept and principle of family planning services, as stated in the 1967 Amendments to the Social Security Act. . . . The objectives of family planning services are: 1) To promote the health of mothers, children and entire families. 2) To help reduce maternal and infant mortality. 3) To make family planning available in a manner that is acceptable and accessible. 4) To provide individuals and families freedom of choice to determine the number and spacing of children."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services *requires* local welfare agencies both to *refer* eligible public assistance recipients to family planning resources and to *purchase* family planning services on their behalf.

The policy, therefore authorizes reimbursements to hospital outpatient clinics, voluntary agencies, private physicians and any other "physician supervised vendor of services." Health departments are not authorized to receive reimbursement under the policy. The Department reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures: "The rate of reimbursement is the physician's 'usual and customary charge' which may not exceed computer computed maximums which are not available." These "maximums" are presumably available from Hospital Service, Inc., and Iowa Medical Service, the fiscal agent for the Medicaid Program.² There are currently no contracts with providers of family planning services for the provision of family planning services but such con-

tracts are reported to be in the process of being drawn up.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance are eligible for referral and/or counseling and residents of low-income areas are eligible for referral services only. General Assistance recipients are eligible for referral and/or counseling only.

There are no additional limitations that affect the provision of services to adults. Parental consent is not an absolute requirement for the provision of services to minors but it is desirable except for married minors and minors with out-of-wedlock child or children.

4. *Administration:*⁴ Responsibility for the administration of the welfare family planning program in Iowa rests with the Bureau of Family and Children's Services and the Community Service Division within the Department of Social Services. There is one full-time Family Life and Family Planning Specialist. Family planning activities of the Bureau and the Division include the training of local welfare staff, development and distribution of public educational materials, and consultation in community resource development.

5. *Financing:*⁵ The Department of Social Services received no specific appropriation for family planning from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Social Services has no written policy on sterilization, but the CFPPD survey indicated that the Department *requires referral for* and the *purchase of* sterilization procedures by local welfare agencies for eligible public assistance recipients wishing them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Iowa Medicaid Program, family planning services are "Provided. Including drugs, supplies, and devices. . . . Reimbursement on variable basis according to type of provider furnishing the service." The 1970 City University of New York Study reported that \$62,918 was expended for contraceptive drugs and devices by the Iowa Medicaid Program in fiscal year 1969. Projected fiscal year 1970 expenditures for drugs and devices were \$76,542.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Kansas

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: In 1965, the Kansas legislature directed the State Board of Health to "establish and maintain family planning centers in cooperation with county social welfare offices and county health departments." These centers are required to serve, upon request, "any person who is over 18 years of age and who is married or who has been referred to said center by a licensed physician and who resides in this state." The family planning centers, upon request of any of the above categories of persons, may furnish and disseminate to them information "and means and methods of planned parenthood, including such contraceptive devices as recommended by the state board of health." Kan. Stat. Ann. §§ 23-501, 23-502 (1970 Supp.)

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: Prohibitions against the advertising or dissemination of information regarding devices for the prevention of conception were repealed in 1963. Thus Kansas currently has no restrictions on advertising or display of contraceptive drugs or appliances.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 21, except that every person 18 or older who is or has been married may enter into contracts, sue and be sued, etc. Kan. Stat. Ann. § 38-101 (1970 Supp.).

The emancipation of a minor by his parents may be inferred from the conduct of the parties or other circumstances. *Lewis v. Missouri, K & T Ry Co.*, 82 Kan. 351, 108 Pac. 95 (1910); *Longhofer v. Herbel*, 83 Kan. 278, 111 Pac. 483 (1910).

In 1969, Kansas adopted a statute which provides that any minor 16 or older may consent to medical or surgical treatment where no parent or guardian is immediately available. Kan. Stat. Ann. § 38-123b (1970 Supp.) (This has been interpreted to include an otherwise lawful therapeutic abortion. Attorney General's Opin. No. 70-38-7 (Dec. 11, 1970).)

Independent of the above statute, Kansas has adopted the "mature minor doctrine." In *Younts v. St. Francis Hospital & School of Nursing, Inc.*, 205

Kan. 292, 469 P. 2d 330 (1970), a mother sued on behalf of her 17-year-old daughter for an allegedly unauthorized surgical procedure. The daughter had been visiting her mother in the hospital when a nurse slammed a door on her finger. The nurse asked the daughter if she wanted her finger fixed, and she agreed. Before treating the girl, the resident surgeon in the emergency room called her family doctor and described the injury and the proposed treatment. The family doctor indicated his assent. The court cited the general rule that, in the absence of emergency, parental consent is necessary before treating a minor. The court went on to say that a number of exceptions have been carved out of the general rule.

Noting that the girl was 17 years old and intelligent and capable for her age, and that the surgery was minor, the court applied the "mature minor doctrine," that a minor old enough and intelligent enough to understand the nature and consequences of the proposed treatment can effectively consent to the treatment if it is for his or her benefit.

By statute in Kansas, physicians may examine and treat minors without parental consent for venereal disease including prophylactic treatment for exposure to venereal disease whenever the minor is suspected of having venereal disease or contact with anyone having venereal disease. The physician may but need not inform the spouse, parent, custodian, guardian or fiancé of such person as to the treatment given or needed. The physician incurs no civil or criminal liability for such treatment except for negligence. The statute further provides that the physician shall incur no civil or criminal liability by reason of any adverse reaction to medication administered, provided reasonable care has been taken to elicit from the minor any history of sensitivity or previous adverse reaction to the medication. Kan. Stat. Ann. § 65-2892 (1970 Supp.)

An unmarried pregnant minor may consent to medical care related to her pregnancy where no parent or guardian is available. Kan. Stat. Ann. § 38-123 (1970 Supp.)

A 1971 law enables the State Department of Social Welfare to consent to medical treatment for a dependent and neglected, delinquent, miscreant, wayward or truant child who has been committed to that department or to any institution under its con-

trol. House Bill No. 1596, chapter 152, approved April 13, 1971.

We have seen that a Kansas statute provides that the state board of health shall establish family planning centers which may furnish birth control services "upon request of any person who is over 18 years of age and who is married or who has been referred to said center by a licensed physician and who resides in this state." (See *State Laws Establishing Family Planning Programs*, above.) It would appear that this statute authorizes birth control services to persons younger than 18 who are referred by a licensed physician and who reside in Kansas, without any requirement of parental consent. Most local health departments do, in fact, provide birth control services without parental consent to minors younger than 18 "who are at risk of becoming pregnant." (See *Health Policy—Eligibility*, below).

However, when the Attorney General was asked recently about "the legality of providing birth control pills or contraceptive devices to minors without the consent or knowledge of their parents or guardians" under Kan. Stat. Ann. §§38-123, 38-123b and 65-2892 (discussed above), he replied:

They [the above-cited statutes] provide no basis, in our opinion, for a determination that the Legislature intends to forbid or encourage the dissemination of birth control information to minors under the age of 18, with or without the consent of a parent or guardian. However, the Legislature has clearly defined the scope of services to be furnished, and class of persons to be served, by family planning centers established under K.S.A. 23-501, *supra*, and it has done so without regard to the consent or lack of consent of persons under eighteen years of age. Letter from Attorney General Vern Miller to Mr. James A. Wheeler, March 19, 1971.

A request for clarification of the above-quoted opinion elicited the following response:

[B]irth control information can be distributed to minors, without parental consent, with no resulting violation of Kansas law, except where the family planning centers of K.S.A. 23-501 [family planning centers established by the state board of health under the statute] are involved. Letter from John C. Johnson, Legal Intern to John R. Martin, First Assistant Attorney General, to Mrs. E. Paul, Jan. 6, 1972.

B. Laws Relating to Voluntary Sterilization

In 1965, a Kansas statute which provided for the compulsory sterilization of certain inmates of state hospitals and prisons was repealed.¹ The repeal of this law,² plus the new legislative provisions and the Attorney General's opinion quoted below, make it clear that voluntary sterilization is now legal in Kansas.

A 1971 statute provides that "[n]o person shall be required to perform or participate in medical procedures which result in the sterilization of a per-

son. . . ." Nor can any hospital be required to permit sterilization procedures to be performed there. No person or hospital can be subject to civil liability arising from refusal to perform sterilization procedures. House Bill No. 1307, ch. 206 (1971).

In addition, the statute provides that "[a] hospital may establish criteria and procedures under which sterilizations may be performed within its institutions." *Ibid.*

We have seen that Kansas has a statute requiring the State Board of Health to establish and maintain family planning centers in cooperation with county social welfare offices and county health departments. Such family planning centers may furnish "information concerning, and means and methods of planned parenthood, including such contraceptive devices as recommended by the state board of health." (See *Laws Establishing Family Planning Programs*, above). It is not clear whether "means and methods of planned parenthood," under this statute includes voluntary sterilization. However, the CFPPD survey indicates that the Department of Health refers and pays for voluntary sterilization for men and women who wish it and the Department of Social Welfare authorizes referral and payment for sterilization procedures for eligible public assistance recipients wishing them (See *Health and Welfare Policies* sections, below).

Minors: In the opinion of the Attorney General of Kansas, sterilization is a medical question with the usual doctor-patient laws applying, and in the case of sterilization of a minor child the consent of either [his or] her parents or guardian would have to be obtained. *Letter from Assistant Attorney General Richard L. Meyer to Mr. R. E. Miller, Feb. 17, 1970.* However, in Kansas, any minor 16 or over may consent to medical or surgical treatment where no parent or guardian is immediately available.

Footnotes:

1. Kans. Sess. Laws 1965, ch. 477, repealing Kan. Stat. Ann. §§ 76-149 to 155 (1964).
2. See 14 Kan. L. Rev. 271, 292 (1965).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The official written policy on family planning of the Kansas State Department of Health consists of a "Board Policy Statement," dated April 30, 1965, entitled "Family Planning—Senate Bill 230." The entire text of the policy is as follows: "The Board of Health recommends accepted means and methods of planned parenthood to include the rhythm method, oral contraception, and mechanical and chemical barrier devices. This wide selection will permit the practicing physician to prescribe methods according to his best medical judgment and the need of his patient."

Additional state health agency policy relating to eligibility for family planning services is contained in a letter from the Director of the Department's Division of Maternal and Child Health to the Region VII Program Management Officer, National Center for Family Planning Services, DHEW, dated November 4, 1970. The policy derives from a 1965 Kansas statute, K.S.A. 1968 Supplement, 23-501 and 23-502 (See Laws Relating to Contraception above).

2. *Eligibility:* The Department of Health establishes social eligibility requirements through policy based on the 1968 statute cited above.¹ Under the policy, clinic services are available to persons who are over 18 years of age and who are married or who are referred by a physician. In the case of an unmarried adult, "this has been broadly interpreted by most community clinics so that the clinic physician himself may make a referral," according to the letter cited above. With respect to minors, local health departments' practices vary: "A number attempt to obtain parental consent for those under 18; however, most do see persons who are at risk of becoming pregnant, regardless of age," according to the Director's letter cited above.

There is no financial screening required or carried out in local clinics; "however, most patients are self-selected, low-income," according to the Department's response to the CFPPD survey. No geographical eligibility requirements or patient fees are recommended or established in health agency policy.

3. *Administration:*² The Division of Maternal and Child Health has administrative responsibility for family planning services in the Department of Health. Staff assigned to family planning activities at the state level include: the MCH Director, 25-50 percent time; the Family Planning Project Director, full-time; seven project nurses in rural areas, full-time; one social worker, 25-50 percent time; one nurse educator, full-time; one consultant school health nurse, 10-25 percent time; two consultant MCH nurses, 10-25 percent time; one health educator, 10-25 percent time; five program workers on rural projects, 10-25 percent time; and one secretary, full-time.

The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; purchase or provision of supplies, equipment, or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and financial contribution of one-half of salaries for maternal and child health nurses with part-time responsibility for family planning in 27 counties.

4. *Financing:*³ \$87,789 of new MCH funds were allocated to the Department of Health in FY 1971

which were federally earmarked for family planning. Of these funds, an estimated \$63,395, or 72 percent, were obligated for family planning activities. The total allocation to the state of non earmarked MCH funds for FY 1971 was \$391,981. An estimated \$60,000 of these funds were spent for family planning services. The Department received a \$70,000 appropriation for family planning from the state legislature in FY 1971. Additional state health agency funds amounting to approximately \$15,000 were spent for family planning health education materials.

5. *Voluntary Sterilization:* The Department of Health has no current written policy in regard to voluntary sterilization; however, in the CFPPD survey, the Department indicates that "patients requesting sterilization in family planning clinics are considered for same. . . Support [is] given in some cases." As indicated in the survey, such services encompass *referral* to and *purchase* (or provision) of voluntary sterilization for men and women.

Footnotes:

1. The Department of Health indicated in the CFPPD survey that eligibility requirements for family planning are established by the Department. In the letter cited above, however, the Department cites the provisions of the 1968 statute without specific reference to its own written policies. Therefore, on the basis of both sources, it is assumed in this analysis that the citation of the statute in the letter means, in effect, that the Department has adopted the provisions of the statute as agency policy.
2. Information contained in this section was reported by the state health agency in the CFPPD survey.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Kansas is contained in State Directive L-464 and in a June 23, 1966 memorandum to "Physicians Serving Kansas Welfare Patients" issued by the State Director of Social Welfare. Directive L-464, dated June 29, 1965, which went to county welfare boards and welfare directors, states that "in order to develop an effective and useful system of family planning clinics, the Board of Health will be establishing at county request a few family planning clinics on a pilot basis. . . . Counseling relative to family planning shall be the province of the physician or clinic personnel; however, referral to the physician shall be made upon request of the assistance recipient." The memorandum to physicians serving welfare patients provides that "because all counties do not have full time departments of health, the state department of Social Welfare will,

beginning July 1, 1966, pay for physicians' services [family planning] and certain pharmaceuticals when prescribed by a physician." This memorandum also provides "that in no case shall the social worker attempt to interfere in the physician-patient relationship." A fee schedule for medical family planning procedures which is attached to this memorandum is now apparently obsolete. The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Welfare *authorizes* local welfare agencies to *refer* eligible public assistance recipients to family planning resources. Local welfare agencies are authorized but not required to *purchase* family planning services for eligible public assistance recipients.

The policy authorizes reimbursement of hospital outpatient clinics, health departments, and private physicians. There apparently is no policy on the reimbursement of voluntary agencies. The Department reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures.² The Department has no contracts or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. General Assistance recipients are eligible for medical family planning services.

There are no additional limitations that affect the provision of services to adults. Parental consent is required for the provision of services to all minors. Kansas, however, has a law which provides that any minor 16 or over may consent to medical or surgical treatment where no parent or guardian is immedi-

ately available. In addition, a 1971 law enables the Department of Social Welfare to consent to medical treatment for a dependent and neglected, delinquent, miscreant, wayward or truant child who has been committed to that department or any institution under its control.

4. *Administration:*⁴ Administrative responsibility for the welfare family planning program is not assigned to any particular subdivision or unit in the Department of Social Welfare. No staff are specifically assigned either full- or part-time to family planning.

5. *Financing:*⁵ The Department of Social Welfare received no specific appropriation for family planning from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Social Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *authorizes referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients wishing them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Kansas Medicaid program, family planning services are: "Provided. Consisting of physicians' services, drugs, supplies, and devices. . . . Reimbursement on basis of usual, customary, and reasonable fees for physicians' services; acquisition cost plus 50%, for materials. Vendor payments made to physicians and pharmacies." The 1970 City University of New York study reports that \$38,000 was expended for family planning drugs and devices by the Kansas Medicaid programs in fiscal year 1969. Projected fiscal year 1970 expenditures for drugs and devices were \$45,000. For additional information on Medicaid, see Federal Laws and Policies Section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Kentucky

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Kentucky.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

Kentucky has a statute regulating appliances for the prevention of venereal disease. Ky. Rev. Stat. §§ 214.190 to 214.270 (1959). Under the statute, a license is required from the State Board of Pharmacy in order to sell, display or dispose of any appliance for the prevention of venereal disease. An exception exempts physicians and medical practitioners licensed in Kentucky. Under the statute, there are three kinds of licenses: a) Manufacturer—issued only to an actual manufacturer; b) Wholesaler; and c) Retailer—issued only to retail drug stores operated by or employing at least one registered pharmacist. Sales under a retailer license may be made only from the prescription counter and only by a registered pharmacist. Sales under a manufacturer or wholesaler license may be made only to those licensed to sell, or to licensed physicians and medical practitioners. Sale of prophylactics by vending machines or house to house or street solicitation is forbidden.

In *Markendorf v. Friedman*, 280 Ky. 484, 133 S.W. 2d 516 (1939) that part of the statute allowing the issuance of retail licenses to pharmacists only was held constitutional. The Court held void an attempt to limit the issuance of wholesaler licenses to wholesale druggists only. (The statute has since been amended to comply with this ruling.)

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

Under the statute regulating prophylactics discussed above, the display or exposure for sale of prophylactics or their packages is prohibited. Also prohibited is public advertising of the sale or use of prophylactics, except in medical and drug publications and literature enclosed in or around the original package. Ky. Rev. Stat. § 214.230 (1959).

It is also a misdemeanor to publish an advertisement about venereal disease or its treatment except in "didactic or scientific treatises" on illness or "sex conditions." Ky. Rev. Stat. § 438.070 (1971).

4. *Laws Relating to Contraceptive Services to Minors:* "Persons of the age of 18 are of the age of majority for all purposes in this Commonwealth except for the purchase of alcoholic beverages and for the purpose of care and treatment of handicapped children. . . ." Ky. Rev. Stat. § 2.015 (1968).

Kentucky has a comprehensive new statute covering the medical treatment of minors. The new law specifically enables minors to consent to contraception. Ky. Rev. Stat. § 214.185 (as revised by S.B. 309, 1972).

Under the new law, any physician, upon consultation by a minor as a patient, with the consent of such minor may make a diagnostic examination for venereal disease, pregnancy, or alcohol or other drug abuse, and may prescribe for and treat such minor regarding venereal disease, alcohol and other drug abuse, contraception, pregnancy or childbirth, all without the consent of or notification to the parent, parents or guardian of such minor patient. (Treatment under this law does not include inducing of an abortion or performance of a sterilization operation.) In any such case, the physician shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment, except for negligence.

In addition, any emancipated minor or any minor who has contracted a lawful marriage or borne a child may consent to hospital, medical or surgical care. A subsequent judgment of annulment of marriage or judgment of divorce shall not deprive the minor of his adult status once obtained.

The new law also provides that medical and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

The statute provides also that the consent of a minor who represents that he may give effective consent for the purpose of receiving medical or other health services but who may not in fact do so shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

Finally, the law provides that the professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, informing the parent or guardian would benefit the health of the minor patient.

In *Tabor v. Scobee*, 254 S.W. 2d 474 (Ct. App. Ky. 1952), the court held that a physician was not justified in removing the Fallopian tubes of a 20-year-old girl who had been anesthetized for the purpose of an appendectomy. The physician had not obtained the consent of the girl, who was anesthetized, nor that of her stepmother who was in the hospital at the time. The opinion states that only if there was an emergency making it impossible for the doctor to obtain the consent of *either* the patient *or* stepmother would the jury be justified in finding for the defendant physician.

The *Tabor* case recognizes the "emergency" exception to the requirement of parental consent, an exception now specifically stated in the new Kentucky statute discussed above. The case has also been cited as accepting the "mature minor doctrine" described in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

A Kentucky Attorney General's opinion states:

Until such time as the courts or legislature in Kentucky have specifically acted upon the question . . . voluntary sterilization violates no criminal law, either common or statutory, and is not against public policy." Op. of Atty. Gen., November 2, 1964.

Minors: The comprehensive minors' medical consent law (see Laws Relating to Contraceptive Services to Minors, above) does not include sterilization operations.

In *Holmes v. Powers*, 439 S.W. 2d 579 (Ct. App. Ky. 1968), the Kentucky Court of Appeals held that the county health officer could not sterilize a 35-year-old mentally retarded woman. The court implied in its opinion that, if the woman had been a minor, her parents could have consented on her behalf.

There is a written state Health Department policy of referral and reimbursement for voluntary sterilization. The Department has no age or marital status requirements for voluntary sterilization services. (See Health Policy section, below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current policy of the State Department of Health consists of

a 1971 revision of state health agency policies and guidelines for family planning entitled *Standards and Procedures—Family Planning Service and Clinic's—Guide for Local Health Departments*. The *Standards and Procedures* encompasses the state health agency's philosophy and the purpose of family planning services and policies governing family planning services. The latter includes procedures for approval of requests for assistance from local agencies to the Maternal and Child Health Division, requirements for contracts between the MCH Division and local agencies other than health departments, eligibility standards, standards for referrals, fees, approved contraceptive methods, and consultation by the MCH Division with local agencies. The *Standards and Procedures* also discusses organization of family planning clinics including staffing, scheduling and location of family planning clinics, referral procedures, family planning medical service components, and follow-up requirements.

2. *Eligibility:*¹ Social eligibility requirements for family planning services are recommended by the state health agency but are locally determined. The CFPPD survey was conducted prior to enactment of the 1972 law which enables minors to consent to contraceptive services (see Laws Relating to Contraceptive Services to Minors, above). Under the old policy, all categories of adults were eligible for family planning services; all minors were eligible for services, but except for emancipated minors they required parental consent. No financial or geographical eligibility requirements are established or recommended by the state health agency.

3. *Administration:*² The Division of Maternal and Child Health has administrative responsibility for the family planning program in the Department of Health. Professional and clerical staff assigned to family planning activities include: the Family Planning Program Director, 25–50 percent time; two full-time nurse consultants, two full-time stenographers, and one full-time statistician. The Division performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$217,087 of new MCH funds were allocated to the State in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$931,998. An estimated \$32,693 of these funds were spent for family planning services. The Department of Health received a \$29,-

000 appropriation for family planning from the state legislature in FY 1971. An additional \$31,762 of state funds and \$4,000 of private funds were utilized by the Department for family planning activities in FY 1971.

5. *Voluntary Sterilization*:⁴ The state health agency has a written policy in regard to sterilization which encompasses *referrals* and *provision* or purchase of voluntary sterilization services for females and males. There are no income, marital status, age or parity requirements for voluntary sterilization services.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey. The guide cited above contains no specific eligibility policy.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
4. Ibid.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Kentucky is contained in Section 6118 of the Manual of Operation of the Department of Economic Security, dated May 29, 1969. Section 6118 states that "Family planning services may include medical contraceptive services as well as social and educational services. . . . The objective of the Department's family planning program is to: (1) assist parents in attaining and maintaining the family size they desire; (2) assist families in spacing their children; (3) decrease infant and maternal mortality and morbidity; (4) decrease out-of-wedlock births; (5) decrease the incidence of prematurity; (6) decrease the incidence of mental retardation and congenital defects; (7) improve understanding of family life and human sexuality."

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Economic Security *recommends* that local welfare agencies *refer* eligible public assistance recipients to medical family planning resources and also *recommends* that local agencies *purchase* medical contraceptive services for these individuals.

The policy, however, authorizes reimbursement only to private physicians. Hospital outpatient clinics, health departments, and voluntary agencies are not authorized to receive reimbursement under the policy. Welfare clients are apparently expected to rely on family planning services available through local health departments and other public agencies, but Section 6118 states that "Although family planning services are available in a majority of the local

health departments, the provision of these services is optional with the local health department." There is no single, standard statewide reimbursement rate for medical family planning procedures.² The Department has no contracts or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of Federally-aided assistance are eligible for medical family planning services. Applicants, past recipients and potential recipients of such assistance and residents of low-income areas are not eligible for medical family planning services. Apparently, there is no general assistance program which is administered by the state.

There are no additional limitations that affect the provision of services to adults. Section 6118 of the Manual contains some language indicating a requirement of parental consent for all minors except those who are married or emancipated. The Manual, however, predates the 1972 law which enables minors to consent to contraceptive services. (See Laws Relating to Contraceptive Services to Minors, above).

4. *Administration*:⁴ Responsibility for the administration of the family planning program rests with the Division of Field Services in the Bureau of Public Assistance under the Department of Economic Security. No staff are specifically assigned either full- or part-time to family planning, but family planning activities of the Division include the training of local welfare staff and the development and distribution of educational materials.

5. *Financing*:⁵ The Department of Economic Security received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Economic Security has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in these sections was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Kentucky Medicaid Program, family planning services are "Provided. Limited to physician's services and prescription drugs. Supplies and devices are not provided. . . . Reimbursement to physicians on basis of usual, customary, and prevailing fee system." The extent of utilization of the Medicaid Program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD Survey.
4. Ibid.
5. Ibid.

Louisiana

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* The Louisiana legislature in 1968 gave police juries the power to provide for the "poor and necessitous" within their parish by various programs and services, including family planning. La. Rev. Stat. § 33.1236 (11) A (g) (Cum. Supp. 1971.)

Under the chapter establishing Municipal Anti-Poverty Powers, municipalities are given the same power as police juries with respect to providing family planning services for the "poor and necessitous." La. Rev. Stat. § 33.7501 A (g) (Cum. Supp. 1971).

The language in both § 33.1236 and § 33.7501 authorizes appropriate programs and activities including "family planning and assistance therein by all appropriate means, in a manner consistent with individual moral, philosophical, and religious beliefs."

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found. (See discussion of Attorney General opinions under 3, below.)

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Louisiana has a statute which makes it a crime to advertise "any secret drug or nostrum exclusively for the use of females for preventing conception." La. Rev. Stat. § 14.88 (1950). This statute has never been judicially construed; an article in the *Louisiana Law Review*¹ states that § 14.88, the Louisiana law on birth control, has never been and in all likelihood will never be enforced.

In a 1965 opinion, the Attorney General, construing § 14.88, ruled that the State Board of Health could engage in a federally sponsored program dealing with family and fertility studies, and that such a program is not prohibited by § 14.88 since it does not contemplate publication of an advertisement of a secret drug or nostrum for preventing conception, nor will the material be exclusively for the use of females, and moreover, since the program will be under medical supervision and control, there are no "secret" drugs or nostrums involved. Op. Atty. Gen. 1965, p. 300.

Section 14.88 had previously been interpreted by the Attorney General as being designed to prevent birth control. A 1933 opinion stated that birth con-

trol in any form would fall within Acts 1920 No. 88 and No. 95 (currently § 14.88) "which were criminal statutes tending to prevent birth control." Op. Atty. Gen. 1932-34, p. 128. A 1934 opinion stated that the manufacture, distribution or sale of contraceptives in Louisiana would be illegal under § 14.88. Op. Atty. Gen. 1934-36, p. 73. In both of these opinions, the Attorney General stated that although no law had been passed in Louisiana relative to birth control, the criminal prohibition against advertising contraceptives (now § 14.88) "tends to prevent birth control." The 1965 opinion would appear to overrule these earlier opinions.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority in Louisiana is 21. La. Civ. Code Art. 37 (1952).

Married minors may consent to surgery "without the aid or assistance" of parents or others. Op. Atty. Gen. April 11, 1958.

In emergencies, a physician may treat a minor in accordance with the usual practice among physicians in the locality without the express consent of a parent, where a reasonable effort to locate the parent has been made. *Wells v. McGehee*, 39 So. 2d 196 (La. App. 1949) (involved 7-year-old girl who died after doctor administered chloroform to set fractured arm). See also *Rogers v. Lumberman's Mutual Casualty Co.* 119 So. 2d 649 (La. App. 1960).

A minor who is or believes himself to be afflicted with a venereal disease may consent to medical care, and physicians are relieved of civil or criminal liability except for negligence in providing such treatment without parental consent. Physicians may but are not obligated to inform the spouse, parent or guardian of any minor so treated. La. Rev. Stat. § 40:1065.1 (1971 Cum. Supp.)

Minors who are emancipated are removed from the legal control of parents or others. See La. Civ. Code Art. 216 (1952) (Parental Authority). Under Louisiana's Civil Code, a minor can be emancipated by marriage, by judicial order, and by notarial court. La. Civ. Code Art. 365 (1952).

Marriage works an irrevocable emancipation as of right. La. Civ. Code, Art. 379. In *In re Greer*, 184 So. 2d 104 (La. App. 1966) it was held that a 13-year-old girl who was emancipated by marriage and widowed eight months later remained emancipated and did not resume her previous legal inability to contract.²

Under Louisiana law marriages of minors are valid even if performed in violation of directive provisions in the Code concerning such matters as the requirement of parental consent,³ the required waiting period after issuance of a marriage license, and the prohibition against performing a marriage ceremony involving a female younger than 16.⁴

Although the Code makes a distinction between the rights of married minors older than and younger than 18,⁵ the Attorney General, without regard to such distinction, has stated (as noted above Op. Atty. Gen. Apr. 11, 1958) that married minors may themselves consent to surgery.

A minor older than 18 may also be emancipated by judicial order which would relieve the minor "of the disabilities which attach to minority." La Civ. Code Art. 385 (1972 Cum. Supp.)⁶ Parental consent is necessary for judicial emancipation except if the minor is seeking emancipation because of "ill treatment, refusal to support, or corrupt examples." La. Code Civ. Proc. Art. 3992 (1961). See *Gaston v. Rainach*, 141 La. 162, 74 So. 890 (1917), *State ex rel. Billington v. Sacred Heart Orphan Asylum*, 154 La. 883, 98 So. 406 (1923); *Emancipation of Dupuy*, 196 La. 439, 199 So. 384 (1941); *Speziale v. Kohnke*, 250 La. 469, 194 So. 2d 485, writ refused 196 So. 2d 534 (1967).

A minor, 15 years or older, may be emancipated by notarial act with the consent of his or her father, or if none, his or her mother. La Civ. Code Art. 366 (1952). The emancipation conferred by Art. 366 grants only the power of administration of one's estate. We have found no information indicating whether a minor emancipated for purposes of administering his own estate is relieved of parental control so as to be able to consent to his own medical services.

In *Wells v. McGehee*, *supra*, the court stated that Louisiana follows the general rule of requiring parental consent for medical services to minors. However, this case involved treatment of a seven-year-old minor. We have found no cases indicating whether Louisiana courts would accept the "mature minor doctrine" described in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.⁷

Under Louisiana Law a "neglected child" is one whose parent "neglects or refuses, when able to do so, to provide . . . medical, surgical or other care necessary for his well-being La. Rev. Stat. 13:1570 A. (1) (1968). Such a neglected child comes under the jurisdiction of the Juvenile Court. "Whenever a child concerning whom a petition has been filed [in the Juvenile Court] appears to be in need of medical or surgical care, the court may order the parent, tutor or other person or agency having care of the person of the child to provide treatment for

such child in a hospital or otherwise." La. Rev. Stat. 13:1583 (1968).

For purposes of determining jurisdiction of the Juvenile Court, "child" is defined to mean "a person less than seventeen years of age, and no exception shall be made for a child who may be emancipated by marriage or otherwise." La. Rev. Stat. 13:1570. (But see *State v. Gonzales*, 241 La. 619, 129 So. 2d 796 (1961); *State v. Golden*, 210 La. 347, 26 So. 2d 837 (1946); *State v. Priest*, 210 La. 389, 27 So. 2d 173 (1946); *In re State in Interest of Goodwin*, 214 La. 1062, 39 So. 2d 731 (1949), where the Louisiana Supreme Court held that the juvenile courts did not have jurisdiction over female minors younger than 17 who were emancipated by marriage.)

Any municipality may provide family planning for poor persons "in a manner consistent with individual moral, philosophical and religious beliefs." There is no restriction as to age or marital status. (See Laws Establishing Family Planning Programs, above.) In the absence of cases in point, it is not clear whether this statute removes any requirement of parental consent for minors. The health department apparently requires parental consent for all but those minors who are or have been married or pregnant, while the welfare department apparently requires parental consent for all minors. (See Health and Welfare Policy sections, Eligibility, below.)

Footnotes:

1. McCoy, "Constitutionality of State Statutes Prohibiting the Dissemination of Birth Control Information," 23 La. L. Rev. 773 (1963).
2. This case concerned the minor's legal capacity to prosecute a claim in the courts and to negotiate a settlement out of court for the death of her husband.
3. La. Civ. Code Art. 97 (1952) requires the consent of parents to the marriage of a minor. But see La. Civ. Code Art. 112 (1952) which provides that the marriage of a minor contracted without parental consent cannot for that cause be annulled. In *State v. Golden*, 210 La. 347, 26 So. 2d 837 (1946) a 15-year-old girl who married without the consent of her parents was held validly married (and therefore not a delinquent in being absent from her parents' home) despite Art. 97.
4. La. Civ. Code Art. 99 (1952) requires a waiting period of 72 hours after obtaining a marriage license before the parties may marry. La. Civ. Code Art. 92 (1952) prohibits ministers and magistrates from marrying any female under 16. Nonetheless the marriage of a 14-year-old girl performed within 72 hours after issuance of a marriage license was held valid despite Art. 92 and Art. 99. In *re State in Interest of Goodwin*, 214 La. 1062, 39 So. 2d 731 (1949). See also *State v. Priest*, 210 La. 389, 27 So. 2d 173 (1946).
5. Under the Code, emancipation by marriage produces different effects according to the age of the person thus emancipated. La. Civ. Code Art. 382 (1972 Cum. Supp.) provides that when a minor emancipated by marriage reaches the age of 18, he or she is relieved of all the disabilities of minority and shall have the full powers of one 21 years of age. In *Succession of Hecker*, 191 La. 302, 185 So. 32 (1938) this provision was construed to work full emancipation of a married minor older than 18 despite the fact that the marriage was without the father's con-

sent. See also *Stough v. Young*, 185 So. 476 (La. App. 1938).

Art. 382 further provides that a "married minor below the age of 18 years has the power of administration of his estate, but he cannot alienate, affect, or mortgage any of his immovable property without the authorization of the court. . . . The authority of the tutor or undertutor, or of the administrator of his estate, of such a minor continues for these purposes after the minor's marriage until the minor reaches the age of 18 years." However it has been held that a married minor younger than 18 can alienate his *movable* property without court approval. *In re Greer*, *supra*, and can bring suit without assistance, *Jefferson v. Jefferson*, 246 La. 1, 163 So. 2d 74 (1964). In *In re State in Interest of Goodwin*, *supra*, it was held that a 14-year-old girl emancipated by marriage, though not relieved of all the disabilities of minority until she reaches 18, is relieved of parental control (and is therefore no longer subject to the compulsory school attendance law). See also *State v. Gonzales*, 241 La. 619, 129 So. 2d 796 (1961).

6. See La. Civ. Code of Civil Procedure, Arts. 3991 to 3994 (1961) for procedures of judicial emancipation.
7. However, Louisiana law does recognize a difference between young and older minors in contexts which may have a bearing on their rights to secure, without parental consent, medical services in general and family planning services in particular. See La. Civ. Code Art. 36 (Age of Puberty), "Males under 14 and females under 12 are under the age of puberty, while those who have attained the age of 14 and 12 are adults." This article has been construed to be applicable to the age at which minors may contract marriage, *Riley v. Cowgill*, 8 La. App. 674 (1928); *Marquette v. Cangelosi*, 148 So. 88 (La. App. 1933); and to statutory rape, *State v. Tilman*, 30 La. Ann. 1249, 31 Am. Rep. 236 (1878). See also *Southworth v. Bowie*, 1 Mart. (N.S.) 537 (1823) (where it was held that a minor above the age of puberty may contract if the engagement be advantageous to him).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

As seen above, under Laws Establishing Family Planning Programs, Louisiana has a statute allowing any municipality to provide poor persons with "family planning and assistance therein by all appropriate means. . . ." It is not clear whether "family planning by all appropriate means" includes voluntary sterilization.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*:¹ The State Board of Health passed a resolution on July 23, 1965, "approving and directing the State Health Department to cooperate and assist the Tulane University School of Medicine in its Maternal and Infant Care Project (including family planning) which was initiated in Lincoln Parish." On November 4, 1967 the Louisiana State Board of Health further approved and directed the Louisiana State Health Department to cooperate with and assist in the development and operation of the family plan-

ning program implemented by Louisiana Family Planning, Inc., under the auspices of the Tulane Medical School. On December 17, 1969, a joint memo was issued by the Louisiana State Health Department and the Louisiana Family Planning Program outlining the joint operational policy of the two agencies. Under the joint policy the Louisiana State Health Department continues to be responsible for the prenatal portion of maternal and child health care, and Louisiana Family Planning, Inc., is responsible for the postnatal portion of the program.

2. *Eligibility*:² Under state health agency policy, all adults (persons aged 21 or over) are eligible for family planning services. All minors are eligible for services *with* parental consent, except that those who are or have been married or pregnant do not require parental consent.

The state health agency neither recommends nor establishes financial or geographical eligibility requirements for family planning services. The state imposes no patient fee requirements on local programs unless a contraceptive method is involved which is not available in a clinic in which case a prescription is given.

3. *Administration*: No information available.

4. *Financing*:³ \$236,572 of new MCH funds were federally earmarked for family planning services. A total of \$1,099,765 in nonearmarked MCH funds was allocated to the state for FY 1971. No information is available on the expenditure of these funds. The state health agency received no specific appropriation for family planning funds from the state legislature. No information is available concerning additional health agency expenditures for family planning.

5. *Voluntary Sterilization*: No information available.

Footnotes:

1. Information on state health agency family planning policy contained in this section was taken from a letter from the State Health Officer to the Region VI Program Director, the National Center for Family Planning Services, DHEW, dated November 12, 1970, and subsequently verified by the State Health Officer in September 1971.
2. *Ibid*.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Louisiana is contained in Chapter XIII, Part VII, of the *Manual for Services for Families and Children* of the Louisiana Depart-

ment of Public Welfare, dated November 15, 1970. Section 13-730 of Chapter XII states: "Family planning is a medical service that should be provided by persons competent in the field of medicine. . . . The role of service workers shall be to refer clients to family planning resources when appropriate, and to support clients in their use of the service." The objectives of the family planning program as stated in Section 13-710, "are to improve the health of recipients and to provide families the freedom of choice to determine the spacing and number of their children, thereby strengthening the integrity of the family." Significant family planning policy is also contained in "An Agreement Relative to Family Planning Services for Applicants and Recipients of Aid to Dependent Children Assistance in Louisiana," between the Department of Public Welfare and a nonprofit corporation, Family Planning, Inc., dated July 7, 1971.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* applicants and current recipients of AFDC² to Family Planning, Inc. The above cited contractual agreement states that the Department of Welfare will provide Family Planning, Inc. with the name, address, and Department of Public Welfare identification number of each applicant for and recipients of Aid to Dependent Children Assistance." Individuals referred to Family Planning, Inc. are eligible for "At least four (4) visits per year to the family planning clinic for the purpose of counseling in health education." The agreement further provides that eligible individuals will receive "an annual medical examination by a qualified physician, such examination to include a Pap Smear cancer detection test and such other laboratory tests as may be medically indicated by the examination." Contraceptive supplies are furnished at no cost to the patient. The agreement states that the Department of Public Welfare will pay Family Planning, Inc. \$83,333 per month for the provision of these services to all eligible individuals throughout the state. No other providers of family planning services are authorized to receive reimbursement under the policy.³

3. *Eligibility:* Applicants and current recipients of AFDC are eligible for medical family planning serv-

ices. Past and potential recipients of such assistance and residents of low-income areas are apparently eligible for referral services only. Current and past recipients of other Federally aided assistance programs and General Assistance recipients are eligible for referral services only. The Department reported that individuals not covered by the AFDC program "are eligible to apply for and receive [medical family planning] services from Family Planning, Inc."

Only married and unmarried adults with children are eligible for family planning services. Parental consent is required for the provision of services to minors. According to Section 13-760 of the policy, "The service worker shall not refer minors to any family planning resources without the consent of parent or guardian."

4. *Administration:*⁴ Responsibility for the administration of the family planning program rests with the Division of Services to Families and Children in the Department of Public Welfare. No staff are assigned either full- or part-time to family planning, but the Division is engaged in the training of local welfare staff.

5. *Financing:*⁵ There is a specific state appropriation for family planning in the Louisiana Department of Public Welfare. In the state's last fiscal year, which ended June 30, 1971, there was an appropriation of \$250,000 to the Department of Public Welfare.

6. *Voluntary Sterilization:*⁶ The Department of Public Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Information reported by the state welfare agency in the CFPPD survey.
2. Aid to Families with Dependent Children; Title IV-A of the Social Security Act.
3. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Louisiana Medicaid program, family planning services are "Not provided." However, this publication is based on data as of January 1970 and the Louisiana Medicaid program may have been modified since that date. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
4. As reported in CFPPD survey.
5. Ibid.
6. Ibid.

Maine

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Maine.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found, except for a 1971 statute forbidding the refilling of prescriptions for oral contraceptives "from a copy of the original prescriptions." Me. Rev. Stat. Ann. i tt. 22, § 2212-A (1971).

Maine has a statute governing the sale and disposition of articles for the prevention of venereal disease. Me. Rev. Stat. Ann. tit. 22, §§ 1131 to 1143 (1964). No such prophylactic article can be sold or disposed of without a license. There are two kinds of licenses under the statute: a) Wholesale—issued only to wholesale druggists, jobbers or manufacturers; licensees under this category may sell only to duly licensed retailers; b) Retail—issued only to registered and licensed retail drug stores. Note that this statute makes no exception for doctors.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* In 1967 Maine repealed its statute prohibiting publication, sale or distribution of written information pertaining to the prevention of conception.¹ Thus, there is now no state law restricting the advertising or display of contraceptive drugs or appliances.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 18. Chapter 598, H.P. 1581—L.D. 2038 (1972 First Special Session.)

A licensed physician who, in the exercise of due care, treats a minor for venereal disease (or drug abuse) is under no obligation to obtain the consent of or inform the parent or guardian of such minor. Maine Rev. Stat. Ann. tit. 32, § 3154 (Cum. Supp. 1972).

Although we have found no cases involving the right of emancipated minors to consent to medical treatment, Maine courts do view emancipation as an "entire surrender on the part of the parent of all right to the care and custody of the child, as well as its earnings, with a renunciation of all duties arising from such a position. It leaves the child, so far as the parent is concerned, free to act upon its

own responsibility, and in accordance with its own will and pleasure, with the same independence as though it were 21 years of age." *Lowell v. Newport*, 66 Me. 78 (1876); *Merithew v. Ellis*, 116 Me. 468, 102 Atl. 301 (1917). It may be presumed, therefore, that Maine courts would follow the general pattern of permitting an emancipated minor to consent to his or her own medical care without the necessity of parental consent.

Maine has many judicial decisions defining emancipation, most of them rendered in connection with Maine law regarding settlement for poor-relief purposes. See Maine Rev. Stat. Ann. tit. 22, § 4451 (as amended by Ch. 598, H.P. 1581—L.D. 2038, 1972 First Special Session). When a minor is emancipated, he or she does not take the subsequently acquired settlement of the parent for poor-relief purposes, but ordinarily retains that of the parent at the time of emancipation.

Emancipation may take place in one of several ways. The marriage of a minor with parental consent works a complete emancipation.² But it has been held that the marriage of a minor son without parental consent did not emancipate him. *White v. Henry*, 24 Me. 531 (1845).

Maine courts have repeatedly held that a parent who abandons a child thereby emancipates it. *Inhabitants of Camden v. Inhabitants of Warren*, 160 Me. 158, 200 A. 2d 419 (1964); *Inhabitants of Carthage v. Inhabitants of Canton*, 97 Me. 473, 54 Atl. 1104 (1903); *Inhabitants of Liberty v. Inhabitants of Levant*, 122 Me. 300, 119 Atl. 811 (1923); *Inhabitants of Thomaston v. Inhabitants of Greenbush*, 106 Me. 242 (1909).

While Maine courts state that emancipation is never presumed but must be proved, nevertheless they hold that it can be implied from circumstances or inferred from the conduct of the parties. *Merithew v. Ellis*, *supra*; *Inhabitants of Trenton v. City of Brewer*, 134 Me. 295, 186 Atl. 612 (1936); *Inhabitants of Dennysville v. Inhabitants of Trescott*, 30 Me. 470 (1849).

A Maine court has also recognized the doctrine of partial emancipation. In *Boobier v. Boobier*, 39 Me. 406 (1855), it was held that a minor, though not completely emancipated, could own property in his own name and sue for conversion. The court stated:

A minor under the age of twenty-one years, may acquire and hold property in his own name, distinct from that of his father, at the time he may be legally subject to the control of the latter. This may be done when the property is the fruit of the minor's earnings if it be obtained by the consent of the father, that it shall be his.³

Consent to medical care is generally dispensed with in an emergency for adults and presumably also for minors. Thus, the Attorney General has stated that "before a physician or surgeon may perform an operation upon a patient he must obtain the consent either of the patient, if competent to give it, or of someone legally authorized to give it for him, unless immediate operation is necessary to save the patient's life or health, although under exceptional circumstances consent may be regarded as having been impliedly given." 1959-60 Atty. Gen. Rep. p. 53.

We have found no cases indicating whether Maine courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

The Department of Health and Welfare can consent to medical or surgical treatment for abused and neglected children in hospitals or infirmaries connected with almshouses. Maine Rev. Stat. Ann. tit. 22, § 3796 (1965).

Under the recommended state health policy, all minors who are married or emancipated or who have been previously pregnant are eligible for family planning services without parental consent. The welfare department requires parental consent only for those persons under 18 who are not married or emancipated. (See "Health and Welfare Policy," "Eligibility," below.)

Footnotes:

1. Me. Rev. Stat. Ann. tit. 17, § 53 (1964).
2. *Inhabitants of Bucksport v. Inhabitants of Rockland*, 56 Me. 22 (1868); see *Inhabitants of Trenton v. City of Brewer*, 134 Me. 295, 186 Atl. 612 (1936). A Maine statute provides that a married person of any age may own and convey real and personal property. Maine Rev. Stat. Ann. tit. 19, § 161 (1965). However, while a married minor may make a binding contract to sell property he cannot make a binding contract to buy property. *Mellott v. Sullivan Ford Sales*, 236 A. 2d 68 (Sup. Ct. 1967). No marriage certificate may be issued to a male or female younger than 18 without parental consent, nor may a marriage certificate be issued to a male or female younger than 16 without the written consent of their parents or guardians and without notifying the probate judge, who may "in the interest of public welfare" order that no such certificate be issued. Maine Rev. Stat. Ann. tit. 19, § 62 (as amended by Ch. 598, H.P. 1581-L.D. 2038, 1972 First Special Session.)
3. 39 Me. at pp. 408-409. See also *Boynton v. Clay*, 58 Me. 236 (1870).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts

the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The CFPPD survey indicates that the Bureau of Social Welfare leaves the question of referral for sterilization procedures to the option of local welfare agencies. (See Welfare Policy, Sterilization, below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The official written policy on family planning of the state health agency consists of a *Statement of Policy and Procedure on Family Planning* authorized by the Commissioner of the Department of Health and Welfare in December 1966. Additional unofficial policy is set forth in a draft *Family Planning "Plan,"* dated December 1971. The 1966 policy authorizes staff of the Division of Public Health Nursing to assist in the assessment of family planning needs, to give information and counseling, to make appropriate referrals to medical family planning resources and to other counseling resources, and to assist parents in carrying out a family planning method. The policy guarantees against coercion or compulsion.

The draft *Plan* sets forth family planning problems, objectives, assumptions, strategy, methods of evaluation, as well as a number of subprograms to be carried out. These subprograms encompass: definition of family planning requirements through the use of demographic data; program design; resource identification; the development of public information and education; the development of family planning services; the formation of a statewide family planning council, and the development of a state family planning association.

2. *Eligibility*:¹ Financial eligibility requirements are established by the Department of Health and Welfare: "We utilize those requirements established by the National Center for Family Planning Services." Social eligibility requirements are recommended by the Department, but are locally determined. Under the recommended policy, all adults are eligible for family planning services; all minors who are married or emancipated or who have been previously pregnant are eligible without parental consent; all other minors require parental consent.

3. *Administration*:² The Division of Child Health has administrative responsibility for family planning services in the Department of Health and Welfare's Bureau of Health. Staff assigned to family planning activities include: a full-time program director and secretary, and the Director of the Division of Child Health, 10-25 percent time.

The Division performs the following functions in support of family planning activities: consultation;

training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment, or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$43,589 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. An estimated \$40,000 or 91.8 percent of these funds were actually obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$286,487. An estimated \$60,000 was spent on family planning services. The Department of Health and Welfare's Bureau of Health received no specific appropriation of family planning from the state legislature; no other state funds were utilized by the Bureau for family planning services.

5. *Voluntary Sterilization:* The Department of Health and Welfare's Bureau of Health has no written policy with regard to sterilization.

Footnotes:

1. Information contained in this section was reported by the Department of Health & Welfare in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Maine is contained in Section 3.7 of the *Title IV—A State Plan of Services Programs for Families and Children*, dated April 1, 1969, and in Chapter III of the *Public Assistance Manual*, dated March 1, 1966. The *Public Assistance Manual* states that "The Division of Family Services recognizes that the right to limit family size is a distinct basic human right and that its clients are entitled to all services, public and private, that are available to other individuals." Section 3.7 states that "Medical services, when provided through a clinic will include the full range of family planning services including physical exam, associated tests, the prescribed appliances or medication, and educational component." The Policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:* Under the policy, the Bureau of Social Welfare leaves the question of *referral* of eligible public assistance recipients to medical family planning resources to *local option*. Local welfare agencies apparently are *not authorized* to purchase medical family planning services.

Although local welfare agencies *do not* themselves *purchase* family planning services, hospital outpatient clinics, voluntary agencies, and private physicians receive reimbursement for medical family planning services provided to eligible persons.¹ Health departments, however, are not authorized to receive reimbursement. There is no single, standard, statewide reimbursement rate for medical family planning procedures. The Department reported that "Some contracts have been made with voluntary agencies for the provision of family planning services."

3. *Eligibility:*² All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only; General Assistance recipients are not eligible for either medical or referral services.

The Department reported that there are no additional limitations that affect the provision of services to adults. However, the written policies conflict on this point. Section 3.7 of the *State Plan*, which is the most recent policy, states that family planning "services will be available without regard to marital status, age, or parenthood." But the *Manual* provides that social workers "shall make available to any Public Assistance client who is a married person and/or a parent any information, written or oral pertaining to subject of family planning." The Department reported that parental consent is required for the provision of services to all persons under 18 except those who are married or emancipated.

4. *Administration:*³ The Social Services Unit of the Bureau of Social Welfare is responsible for the administration of the family planning program. Two Social Services Unit Consultants spend less than 10 percent of their time in family planning activities. Family planning activities of the Unit include the distribution of Public Educational materials and some inservice training of agency staff.

5. *Financing:*⁴ The Department of Health and Welfare received no specific appropriation for family planning services from the state legislature in FY 1971.

6. *Voluntary Sterilization:*⁵ The Department of Health and Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Bureau of Social Welfare leaves the question of referral for sterilization procedures to the option of local welfare agencies.

Footnotes:

1. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Maine Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices. . . . Services must

be rendered under supervision of a physician... Reimbursement to physicians on basis of usual and customary charges." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)

2. Information in this section was reported by the state welfare agency in the CFPPD survey.
3. Ibid.
4. Ibid.
5. Ibid.

Maryland

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Maryland.¹

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found, except for a statute which prohibits the sale of contraceptives by vending machine, regardless of whether the article is advertised as a contraceptive or a prophylactic. Md. Ann. Code art. 27, § 41 (1957). An exception in the statute provides that contraceptives may be sold in vending machines in places where alcoholic beverages are sold for consumption on the premises, but the exception does not include railroad stations, air and bus terminals, nor places in Howard County.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. However, by statute in Maryland, a minor has the same capacity to consent to medical treatment as an adult if the minor is 18, married or the parent of a child, or seeks treatment or advice concerning venereal disease, pregnancy or contraception not amounting to sterilization. Md. Ann. Code, art. 43, § 135 (1971). The same statute protects a physician or person acting under the physician's direction from any civil liability or criminal or disciplinary penalty by reason of the minor's lack of capacity to consent. The statute also provides that it is entirely within the physician's discretion whether or not to inform the spouse, parent, custodian or guardian of a minor as to the treatment given or needed.

Footnote:

1. In a recent case a number of parents of pupils brought an action to enjoin the Maryland State Board of Education from implementing its bylaw stating that it was the responsibility of the local school system to provide a comprehensive program of family life and sex education in every elementary and secondary school. The Board had adopted the bylaw as an appropriate measure for health and education after it studied the problem of pregnant students. The parents alleged that the bylaw violated the First Amendment and the equal protection and due process clauses of the Fourteenth Amendment. The Court held

that the constitutional challenge lacked merit and dismissed the suit. *Cornwell v. State Board of Education*, 428 F. 2d 471 (1970).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.¹

There is a written state Health Department policy of referral and reimbursement for sterilization (See Health Policy, Sterilization, below), and the CFPPD survey indicates that the Department of Employment and Social Services leaves the question of referral for sterilization to the option of local welfare agencies, which are authorized to pay for such procedure for eligible welfare recipients who wish it (See Welfare Policy, Sterilization, below).

Minors: By statute, a minor has the same capacity to consent to medical treatment as an adult if he has attained the age of 18 years, is married or is the parent of a child. Md. Ann. Code, art. 43, § 135 (1971). The same statute provides that a minor shall have the same capacity to consent to medical treatment as an adult if, "in the judgment of a physician treating a minor, the obtaining of consent of any other person would result in such delay of treatment as would adversely affect the life or health of the minor." *Ibid.* This law also permits a minor younger than 18 to consent to "contraception not amounting to sterilization."

Footnote:

1. In the case of *In re Simpson*, 8 Ohio L. Abs. 193, 180 N.E. 2d 206 (Probate Ct. Zanesville Co. 1962), the court refers to an unpublished memorandum opinion of the Circuit Court of Baltimore, in the case of *Ex parte Eaton*, that an order to sterilize a mentally defective person could be made under the general equity powers of the court. This would tend to support the legality of voluntary sterilization in Maryland.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current State Department of Health policy on family planning consists of a *Policy Statement on Family Planning* approved by the Maryland State Board of Health and Mental Hygiene on June 22, 1966, and a *Family Planning Services Guide for Local Health*

Departments issued by the Division of Maternal and Child Health on November 19, 1970. A memorandum from the Chief of the Maternal and Child Health Division, dated July 1, 1971, updates the *Services Guide* with respect to eligibility of minors in conformity with 1971 law (See Laws Relating to Minors, above).

The Maryland State Board of Health's 1966 policy statement recommends that the state and local health departments include voluntary family planning information, education and services as part of their health programs. The policy recommends that a full choice of family planning methods, as well as premarital and genetic counseling services, be included in local programs. It is recommended that services be offered on a voluntary basis and that agency staff be exempt from participation in family planning where their convictions are not in accord with the program.

The *Services Guide* includes sections on: the philosophy and purpose of the family planning program; policies governing family planning services, such as patient eligibility, patient referral, fees, scheduling of family planning clinics, and staff participation; methods of family planning, such as oral contraceptives, intrauterine devices, diaphragm and rhythm; clinic location and staffing; medical services, including initial visit recommendations and return visit recommendations; nursing services; social services; and clinic records, such as medical service records, letters of referral, nursing service records, and nursing statistical reports.

2. Eligibility: There are no financial, social, or geographical eligibility limitations or patient fees recommended or imposed by the Department of Health (as reported by the Department in the CFPPD survey). The *Services Guide* states: "In all local health departments, family planning service should be made available to those who are unable for any reason to obtain this care elsewhere." The July 1971 memorandum cited above updates the Department's eligibility policy on minors in conformity with the 1971 law which provides that minors may give valid consent for treatment related to venereal disease, pregnancy or contraception, "not amounting to sterilization" (See Laws Relating to Minors, above). The eligibility provisions of the *Services Guide* (including the revised provisions on eligibility of minors) appear to constitute recommended policies for local health agencies rather than required or mandated policies.

3. Administration:¹ The Maternity and Family Planning Section, Division of Maternal and Child Health, Bureau of Preventive Medicine, has administrative responsibility for family planning services in the Department of Health. State level staff assigned to family planning responsibilities include:

one Program Director (physician), 65 percent time; three consultant physicians, full-time; one physician consultant, 50 percent time; two nursing consultants, 50 percent time; one social worker, 25 percent time; and a full-time administrator. The Department performs the following functions in support of family planning services: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. Financing:² \$225,368 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning activities. All of these funds were obligated. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$808,362. No estimate of expenditures for family planning services from these funds is available. The Department of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other funds were utilized by the Department for family planning.

5. Voluntary Sterilization:³ The Department of Health reported in the CFPPD survey that it has a written policy in regard to sterilization which encompasses referrals and provision or purchase of voluntary sterilization services for males and females. There is a financial eligibility requirement in effect for these services (policy unavailable).

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
3. As reported in CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. Summary of Current Welfare Policy: Welfare family planning policy in Maryland is contained in Rule 100, Family Planning Services, dated July 1968, and in Rule 300, Single Parent Services, dated September 1970, of the Maryland Department of Employment and Social Services. Rule 100 states that "A mother of childbearing age applying for public assistance or other social services, is to be advised of the availability of family planning services." Additional family planning policy is found in section P-OO-k of the Department's *Programs Manual* which states that the "Purpose of Family Planning Services is to provide families the freedom of choice to determine the number and spacing of their children, to promote the health of mothers and children,

and to help reduce maternal and infant mortality. Its purpose is also to enable the unmarried to avoid having babies out-of-wedlock."

2. Referral and Purchase Provisions:¹ Under the policy, the Department *requires* local welfare agencies to *refer* eligible public assistance recipients to family planning sources. Local welfare agencies are *authorized* but not required to *purchase* family planning services for eligible public assistance recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. The Department reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures.² The rates for these procedures are: Initial medical examination, \$6.00; Annual medical examination, \$6.00; IUD insertion, \$15.00; One cycle of oral contraceptives, usually about \$1.50, plus \$1.75 for handling through the pharmacist.

The Department of Employment and Social Services has no contracts and/or other formal arrangements with providers of family planning services for the provision of family planning services.

3. Eligibility:³ All current recipients of federally-aided assistance are eligible for medical family planning services. The Department reported: "Potential recipients who are applicants for Day Care services or Homemaker services are eligible for social services given by local departments; also those persons whose assistance has been terminated but there is continued need for social services" are eligible for these services. General Assistance recipients are also eligible for medical family planning services. Residents of low-income areas who do not fall in these categories are not eligible for family planning services.

Only married or unmarried mothers appear to be eligible under the policy. The policy, however, is inconsistent on this point. Subsection A of Rule 100 states that "A mother of child-bearing age applying for public assistance or other social services, is to be advised of the availability of family planning services." But the third paragraph of P-OO-k provides: "Family planning services must be offered to a mother of child-bearing age receiving any of the department (sic) services. When the individual wishes, referral shall be made to provide medical contraceptive services (diagnosis, treatment, supplies, and follow-ups), as well as social and educational services. Services are to be available without regard to marital status, age or parenting." Subsection A of Rule 100 and the final paragraph of P-OO-k contain identical sentences which provide that "In cases

involving married persons living together in the home, the availability of such services shall be discussed with both parents." As far as the provision of services to minors is concerned, P-OO-k states that "It should be the general policy not to make referrals of girls under 16; or when the pregnancy resulted from incest or the use of force. It may seem advisable to make referrals in some of these instances. The local director establishes conditions under which such referrals are made with or without supervisory approval. When making referrals of girls under 16 it should be the rule to involve the available parent or responsible adult." Rule 100 contains a nearly identical statement but does not include the sentence on parental involvement.

This policy appears to conflict with a 1971 law which provides that a minor on his or her own consent may receive medical treatment or advice concerning venereal disease, pregnancy or contraception not amounting to sterilization (See Laws Relating to Minors, above).

4. Administration:⁴ The Social Services Administration has responsibility for the family planning program in the Department of Employment and Social Services. Two of the Administration's Specialists spend less than 10 percent of their time in family planning activities. Family planning activities relate mainly to the training of local welfare staff.

5. Financing:⁵ The Department of Employment and Social Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. Voluntary Sterilization: The Department of Employment and Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of *referral* for sterilization to the option of local welfare agencies. Local welfare agencies, however, are authorized to pay for sterilization procedures provided to eligible public assistance recipients who wish it.

Footnotes:

1. Information used in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Maryland Medicaid Program, family planning services are "Provided. Including drugs, supplies, and devices. . . . Reimbursement of physicians on basis of fee schedule." The extent of the utilization of the Medicaid Program for family planning services is unknown. (For additional information on Medicaid see Federal Law and Policy Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Massachusetts

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Massachusetts.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Until 1966 Massachusetts had a law prohibiting selling, lending, giving away or exhibiting any article or drug for the prevention of conception, Mass. Gen. Laws Ann. ch. 272, § 21 (1966 Supp.) It also prohibited the advertising or circulating of any *written* information on preventing pregnancy, Mass. Gen. Laws Ann. ch. 272, § 20 (1966 Supp.)

After the *Griswold case*,¹ the Massachusetts legislature revised this statute by adding a new section permitting registered physicians to prescribe drugs or articles for use in birth control by married persons. It permits registered pharmacists to provide such drugs or articles to married persons furnishing such a prescription. The statute also permits a public health agency, registered nurse or maternity health clinic operated by or in an accredited hospital to furnish married persons information as to where to get professional advice regarding contraceptives. Mass. Gen. Laws Ann. ch. 272, § 21A (1966 Supp.) Though less restrictive than the earlier law, the effect of adding this new section was to continue a prohibition against distribution of contraceptives to unmarried persons and against dispensing of contraceptives even to the married except on prescription, and to continue restrictions on dissemination of information by those other than the groups specified in § 21A. The sale or dispensing of contraceptives by vending machine is prohibited by the new law, as it was under the old.

This Massachusetts statute has been held unconstitutional by the United States Supreme Court in *Eisenstadt v. Baird*, 40 U.S. Law Week 4303 (March 21, 1972). In this case, the state of Massachusetts charged that defendant Baird gave a lecture on birth control to a large group of students; that at the end of the lecture he invited students up to the platform to see some family planning devices and proceeded to give one type to a girl from the audience. Baird was arrested and charged with violating § 21 by exhibiting and delivering a contraceptive article. He contended in the state court that the law was uncon-

stitutional. The Supreme Judicial Court of Massachusetts ruled that that part of the statute prohibiting exhibition of contraceptives was unconstitutional in its application to Baird who was exhibiting those articles in connection with a lecture on such articles. The right of free speech entitled him to deliver a lecture and the display of articles was essential to a graphic representation of his subject. However, the Massachusetts court upheld the ban on distribution of contraceptives to the unmarried. *Commonwealth v. Baird*, 355 Mass. 746, 247 N.E. 2d 574 (1969).

Baird filed a petition for a Federal writ of habeas corpus. Although the lower Federal court denied that writ, the Court of Appeals reversed. Baird's right to distribute contraceptives was finally upheld by the United States Supreme Court on the ground that the statute's prohibition against the distribution of contraceptives except to married persons violates the rights of single persons under the Equal Protection Clause of the Fourteenth Amendment.²

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* See discussion of chapter 272, §§ 20, 21, and 21A above.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority in Massachusetts is 21. *Inhabitants of City of Danvers v. Inhabitants of City of Boston*, 27 Mass. (10 Pick) 513 (1830).³

Physicians and hospitals are exempt from civil liability for failure to obtain spousal, parental or guardian's consent for "emergency examination and treatment [of a minor] . . . when delay in treatment will endanger the life, limb, or mental well-being of the patient." Mass. Ann. Laws ch. 112, § 12 F (1971 Cum. Supp.)

In *Reddington v. Clayman*, 334 Mass. 244, 134 N.E. 2d 920 (1956) it was held that if a person has not attained his majority and is unmarried, the consent of his parents or guardian is necessary for surgery. However, there is no indication in this case of the age of the minor. Minors who are mental patients require parental consent for surgery. Op. Atty. Gen. 1966 p. 247.

We have found no cases on the question of whether Massachusetts courts follow the general common law rule of permitting medical treatment

for emancipated minors without parental consent. However, Massachusetts' courts have held that minors who are emancipated are removed from parental control. *Inhabitants of Taunton v. Inhabitants of Plymouth*, 15 Mass. 203 (1818); *Commonwealth v. Graham*, 157 Mass. 73, 31 N.E. 706 (1892). Thus presumably such minors would not need parental consent for medical services.

Minors can be emancipated by marriage, *Inhabitants of Taunton v. Inhabitants of Plymouth*, *supra*, *Commonwealth v. Graham*, *supra*, or by express or implied agreement, *Abbot v. Converse*, 86 Mass. (4 Allen) 530 (1862). Implied emancipation has been found from the conduct and acts of the parties in many older cases involving for the most part the minor's right to his own wages.⁴ For example, in *Sherry v. Littlefield*, 232 Mass. 220, 122 N.E. 300 (1919) it was held that a minor who had worked away from home and earned her own money but who had given this up to return home "to care and keep home" for her sick mother with an understanding that she "would be taken care of" in the mother's will, had been and remained emancipated.

Magistrates and ministers are directed to "not solemnize a marriage" of minors under 18 who do not have parental consent. Mass. Ann. Laws ch. 207 § 7 (1971 Cum. Supp.). However, the common law age of consent of 14 for males and 12 for females is still in effect in Massachusetts, and a marriage between minors above those ages is valid, notwithstanding a lack of parental consent. *Parton v. Hervey*, 67 Mass. (1 Gray) 119 (1854). See also *Bradford v. Parker*, 327 Mass. 446, 99 N.E. 2d 537 (1951). Mass. Ann. Laws ch. 207 § 9 (1969) provides that "A marriage solemnized when either party is under fourteen if a male, or twelve if a female shall be void, without a decree of divorce or other legal process if the parties separate during such non-age and do not afterward cohabit."

Minors suffering from venereal disease who are unable to pay for private medical care can receive treatment at publicly maintained facilities. Physicians acting under this statutory authority may examine and treat minors without liability for assault and battery. Mass. Ann. Laws ch. 111, § 117 (1967).

We have found no indication as to whether the Massachusetts courts would accept the "mature minor doctrine" described in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

Under Massachusetts law, parents who fail to provide "necessary and proper physical, educational or moral care and guidance" are subject to fine and/or imprisonment. Mass. Ann. Laws ch. 273 § 1 (1971 Cum. Supp.). A 1971 amendment to this section provides that "A child shall not be deemed to be neglected or lack proper physical care for the sole rea-

son that he is being provided remedial treatment by spiritual means alone. . . ."

Footnotes:

1. *Griswold v. Connecticut*, 381 U.S. 479 (1965), held unconstitutional a Connecticut law which prohibited the use of contraceptives.
2. In a case interpreting ch. 272, §§ 20, 21 and 21A after the 1966 amendment, the Supreme Judicial Court of Massachusetts held that these sections of the statute were constitutional insofar as they forbid a registered physician to administer contraceptives or to prescribe them for unmarried persons, and forbid a registered pharmacist to fill prescriptions for contraceptives for unmarried persons. *Sturgis v. Attorney General*, 70 Mass. A.S. 1139, 260 N.E. 2d 687 (1970). This decision was reached after the *Baird* case was decided by the Massachusetts court, but before the United States Supreme Court had held the statute unconstitutional.
3. However, there has been a trend in recent years to lowering the age of majority for various purposes. For example, in 1971, 19-year-olds were given the right to vote in local elections, Acts 1971, ch. 382 § 1. The Donees of Anatomical Gifts Act was passed in the same year permitting persons of 18 to make anatomical gifts, Acts 1971, ch. 113 § 8. The age at which a male may be married without parental consent was lowered in 1971 from 21 to 18, Acts 1971, ch. 255 § 1, so that 18 is now the age of consent for males and females.
4. *McCarthy v. Boston and L.R. Corp.*, 148 Mass. 550, 20 N.E. 182 (1889); *Nightingale v. Withington*, 15 Mass. 272, 8 Am. Dec. 101 (1818); *Whiting v. Earle*, 3 Pick. 201, 15 Am. Dec. 207 (1825); *Corey v. Corey*, 19 Pick. 29, 31 Am. Dec. 117 (1837); *Wodell v. Coggeshall*, 2 Met. 89, 35 Am. Dec. 391 (1840); *Sykes v. Smith*, 333 Mass. 560, 132 N.E. 2d 168 (1956).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The CFPPD survey indicates that the Department of Public Welfare authorizes referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients who wish it. (See Welfare Policy, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The current Massachusetts Department of Public Health policy on family planning consists of a one page *Policy Statement on Family Planning* issued by the Department in June 1967, and a *Consortium Statement* also issued by the Department (unavailable). The *Policy Statement* requires public health personnel to "(1) become knowledgeable of the resources and methods available in family planning . . . , (2) to compile and maintain a directory of available services . . . , (3) to serve as consultants to hospitals and local health agencies in the development of services . . . , (4) to participate in educational, training and

research programs." The *Consortium Statement* sets forth the terms of cooperation among public and private agencies in Massachusetts with regard to the development of family planning services.

2. *Eligibility*:¹ The Department of Public Health neither recommends nor establishes eligibility requirements or patient fees for family planning services.

3. *Administration*:² The Family Planning Program, Bureau of Adult and Maternal Health Services, Division of Family Health Services, has administrative responsibility for family planning services in the Department of Public Health. Staff assigned to family planning activities include: the Division Director, less than 10 percent time; the Bureau Director, 10–25 percent time; a full-time project director; a full-time training director; two full-time area specialists; three full-time social service technicians; one obstetrician-gynecologist consultant; 10 to 25 percent time; one nursing consultant, less than 10 percent time; and twelve regional registered nurses, less than 10 percent time. The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; grants or contracts to support family planning services within the context of maternity care; program development; and community education.

4. *Financing*:³ The Department of Public Health was allocated \$128,180 of new MCH funds in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$718,881. None of these funds were spent for family planning services. The Department received no specific appropriation for family planning services from the state legislature. \$28,100 of state health project funds were spent for family planning services related to maternal care.

5. *Voluntary Sterilization*: The Department of Public Health has no written policy on voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare fam-

ily planning policy in Massachusetts is contained in Section 3.7 of the *Title IV-A State Plan of Service Programs for Families and Children*, dated July 1969. Section 3.7 states that "Family planning services, social, medical and educational will be offered and provided to those individuals wishing such services within the limitations of the laws of the Commonwealth of Massachusetts." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *authorizes* local welfare agencies to *refer* eligible public assistance recipients to family planning resources. Local welfare agencies are *authorized* but not required to *purchase* family planning services for eligible public assistance recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, and private physicians. There is no information as to whether voluntary agencies are authorized to receive reimbursement under the policy. The Department of Public Welfare reported that there is a standard, statewide reimbursement rate for medical family planning procedures.² The rates for these procedures are as follows: initial medical examination, \$7.00–\$12.00; annual medical examination, \$7.00–\$12.00; one cycle of oral contraceptives, \$1.85 above wholesale price.

The Department of Public Welfare has no contracts or other formal arrangements with providers of family planning services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance, all applicants and potential recipients of such assistance, General Assistance recipients and residents of low-income areas are eligible for medical family planning services. There is no information as to whether past recipients of such assistance are eligible for medical services.

Only married adults and minors are eligible for family planning services in Massachusetts. There is no minimum age for the provision of services to minors, but all minors must be married to be eligible for family planning services. The Massachusetts law limiting the provision of family planning services to married persons has been held unconstitutional by the U.S. Supreme Court. (See Laws on Contraception above).

4. *Administration*:⁴ The Office of the Assistant Commissioner for Social Services has administrative responsibility for the family planning program. The Assistant Commissioner for Social Services spends less than 10 percent of her time on family planning activities. The Director of Special Services spends from 10 to 25 percent of his or her time on family

planning activities and one Program Development Specialist spends from 25–50 percent of his or her time on family planning. The Office is engaged in the development of training materials for family planning programs.

5. *Financing:*⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *authorizes referral* for and *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Information was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Massachusetts Medicaid program family planning services are "Provided. Included drugs, supplies, and devices. Must be on recommendation of the physician. . . . Reimbursement on basis of fee schedule where appropriate; otherwise, on basis of reasonable charges." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD Survey.
4. Ibid.
5. Ibid.

Michigan

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Michigan authorizes the State Health Commissioner and local Health Departments or Boards to provide written or oral notice to medically indigent women of the availability of family planning services, and authorizes the provision of family planning services to these women upon their request and in accordance with rules and regulations promulgated by the Commissioner. Mich. Comp. Laws Ann. § 325.7a (1966). The law requires that no effort be made "to suggest or persuade any medically indigent woman to request or not request family planning services and that medically indigent women be notified that receipt of public health services is in no way dependent upon a request or nonrequest for family planning services."

Michigan also authorizes the State Director of Social Welfare and under his supervision, local departments of social welfare, to provide written or oral notice to recipients of public assistance of the availability of advice and treatment in family planning. Upon their request, recipients of public assistance may be referred to a licensed private physician or osteopath, a public agency or private agency of the recipient's choice for such family planning services. Necessary drugs and medical appliances may be made available through licensed pharmacists upon prescription issued by a licensed physician. The law requires that no effort be made "to suggest or persuade recipients to request or not request family planning services, and that recipients be notified that receipt of public assistance is in no way dependent upon a request or nonrequest of family planning services." Mich. Comp. Laws Ann. § 400.14b (1966).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

Articles for the prevention of venereal disease are regulated by Mich. Comp. Laws Ann. §§ 329.251 to 329.255 (1967). Such articles are called "venereal prophylactics"; it is unlawful to sell or give them away individually or through vending machines, § 329.252. An exception to the statute is made for those licensed under Act 237 (1899), as amended and those licensed under Act 162 (1903), as amended, i.e., physicians and osteopaths. Also exempted are registered pharmacists employed on the premises of a licensed drugstore; and wholesalers of prophylactics who sell to retail stores for resale.

In *People v. Pennock*, 294 Mich. 578, 293 N.W. 759 (1940), the Supreme Court of Michigan upheld a Detroit city ordinance limiting the sale of prophylactics to licensed druggists who work in drugstores with prescription counters and who are regularly engaged in filling prescriptions.¹

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Michigan's only restriction concerning contraceptives is Section 750.40 of the Michigan Penal Code. This section makes it a misdemeanor to publish or sell in Michigan any pamphlet or book "in indecent or obscene language" containing a recipe or prescription to prevent conception. Mich. Comp. Laws Ann. § 750.40 (1966).

It is unlawful to advertise prophylactics or to display them in show windows, on the streets or in public places, Mich. Comp. Laws Ann. § 329.253 (1967), but medical and pharmaceutical publications may advertise prophylactics, and federal, state and local departments of health as well as incorporated medical, pharmaceutical or scientific organizations may display prophylactics.

In 1943 an Attorney General's opinion stated that though osteopaths are not prohibited from selling prophylactics through vending machines as per section 329.252, if the vending machines are so constructed as to exhibit or display prophylactics, and if the machines are placed in public places, then the provisions of section 329.253 against display or advertising are violated though the machines are owned by osteopaths. Op. Atty. Gen. 1943-44, No. 0-141, p. 280.

Michigan has a statute which makes it the duty of school boards to provide health and physical education instruction and training in the schools. The law specifies that it is not its intention to give the right of instruction in birth control, and expressly prohibits any person from giving birth control instruction, advice or information in the public schools. Mich. Comp. Laws Ann. § 340.782 (1966).

Michigan's sex education statute, enacted in 1968, Mich. Comp. Laws Ann. §§ 340.789 to 340.789c, defines sex education and authorizes school districts to (they "may") provide instruction in sex education. The Department of Education is directed to (it "shall") aid in the establishment of sex education

in all levels of schools, and also to recommend and provide leadership for sex education instruction established by the local school districts, including guidelines for family planning information.

A 1970 Attorney General's opinion interpreted these statutes as complementary rather than contradictory. The opinion stated that it is state public policy "to encourage and provide for sex education within the schools . . . [S]ex education classes may not include specific instruction in birth control but may include other family planning information such as the social, economic, and psychological implications of various sized family units, effects of population growth upon our natural environment and resources, population studies, and birth and death rates." Thus, section 340.782, prohibiting birth control instruction, has not been superseded by section 340.789b concerning family planning information. Op. Atty. Gen. 1970, No. 4699.

4. *Laws Relating to Contraceptive Services to Minors*: Effective January 1, 1972, the age of majority was lowered to 18. Mich. Comp. Laws Ann. § 722.52 (Cum. Supp. 1972).

Moreover, a recent Michigan statute provides that an emancipation occurs by operation of law when a minor is validly married, during the period when the minor is on active duty with the armed forces of the United States, and if a court of competent jurisdiction orders an emancipation in the best interests of the minor. Mich. Comp. Laws Ann. § 722.4 (Cum. Supp. 1972). The same statute provides:

(2) An emancipation occurs by action of the parents when both parents or a surviving parent or a parent having exclusive rights of custody release their parental rights by written instrument or by conduct which clearly indicates intent to release their rights and such written instrument shall be filed with the county clerk in the county or counties where the parents reside.

(3) Abandonment by the parents is presumptive evidence of emancipation and relinquishment of parental rights.

(4) Emancipation by action of the parents does not occur if the minor is in fact dependent upon his parents for support.

(5) Emancipation by action of the parents or when minor is validly married may be revoked by agreement between the parents or surviving parent and the minor or by a resumption of family relations inconsistent with the prior emancipation.

(6) An emancipated minor may acquire a domicile of his choice.

A recent Michigan decision views the new statute as "adding the authority of statutory law" rather than replacing common law rules regarding emancipation. *Ortman v. Miller*, 33 Mich. App. 451, 190 N.W. 2d 242 (1971). In any event, earlier case law is relevant in determining what conduct "clearly indicates intent to release" parental rights.

An early Michigan case held that a jury could find that a 13-year-old girl was emancipated when her father died and her mother "had given her to understand that she would have to take care of herself, told her she had to make her own living and released her." *Fox v. Schumann*, 191 Mich. 331, 158 N.W. 168 (1916). And where a father hired a son under an agreement to pay the son wages, "there was at least special and partial emancipation" enabling the son to claim Workmen's Compensation. *Van Sweden v. Van Sweden*, 250 Mich. 238, 230 N.W. 191 (1930). However, the court held that a 15-year-old boy was not emancipated who lived at home and went to school, but was allowed to keep 75 cents a week earned for once-a-week assistance to his stepfather in the operation of his milk route. *Mulder v. Achterhof*, 258 Mich. 190, 242 N.W. 215 (1932). (See also *Lincoln v. Detroit & M. Ry. Co.*, 197 Mich. 504, 163 N.W. 969 (1917): Whether a 16-year-old boy who had graduated from high school and was about to go into business with his grandfather was emancipated was a question properly submitted to a jury, who found that he was not.)

A Michigan intermediate appellate court recently held that a 16-year-old high school student could, against the wishes of his parents, continue in his own name a lawsuit alleging that his suspension from high school for failure to cut his hair to the length prescribed by the school dress code violated his constitutional rights. *Buckholz v. Leveille*, 194 N.W. 2d 427 (Mich. Ct. App. 1971). Although the court did not base its holding on the theory of emancipation, the opinion contains the following language:

Courts must stand prepared to protect the rights of all citizens, including teenagers. Denying a teen-aged litigant access to our courts simply because he happens to be a minor not only tends to lessen the confidence of young people in our legal system but adds credence to the existence of the 'generation gap.' And it may even help widen that gap.

Michigan appears to have adopted the "mature minor doctrine" that a minor may consent to medical treatment if he is old enough to understand the nature of the treatment and it is for his benefit. *Bakker v. Welsh*, 144 Mich. 632, 108 N.W. 94 (1906); *Bishop v. Shurly*, 237 Mich. 76, 211 N.W. 75 (1926). Michigan courts also clearly recognize the physician's right to treat a minor in an emergency without waiting for parental consent when the parents cannot be found. *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912).

In *Bakker v. Welsh*, the Michigan Supreme Court held that a 17-year-old boy could effectively consent to a "surgical operation of a not very dangerous character" (removal of a tumor). In *Zoski v. Gaines*, 271 Mich. 1, 260 N.W. 99 (1935), a case involving a

tonsillectomy performed on a nine year old boy without his parents' consent, the court held that *Bakker* was not controlling. Affirming the general principle that a physician must obtain parental consent before undertaking treatment of a minor, the court pointed out that in *Bakker* the minor who consented to surgery was older and was accompanied by adult relatives. The court further pointed out that neither in *Bakker* nor in *Luka v. Lowrie, supra*, was there anything in the record to indicate that the parents would have refused to give their consent to the operation had they been present, whereas in *Zoski* the parents had repeatedly indicated that they did not want their son's tonsils removed.

In *Bishop v. Shurly*, 237 Mich. 76, 211 N.W. 75 (1926), the court held that a 19-year-old boy, whose father was dead, could effectively countermand his mother's direction to a physician with regard to the type of anesthetic to be used for a tonsillectomy; the court pointed out that the boy was old enough to nominate a guardian for his estate.

A Michigan statute provides that a minor who is or professes to be afflicted with a venereal disease can consent to the provision of medical or surgical care or services by a hospital, clinic or licensed physician, and no other person's consent shall be necessary. The treating physician (or, upon his advice, a member of the medical staff of the hospital or clinic) may but need not inform the spouse, parent or guardian of such minor as to the treatment given or needed, and such information may be given to or withheld from the spouse, parent or guardian even over the express objection of the minor. Mich. Comp. Laws Ann. § 329.221 (Cum. Supp. 1972).

Michigan has a law providing for the medical and surgical treatment of children who are afflicted with a curable illness or are pregnant, and whose parents or guardians are unable to provide proper treatment. Mich. Comp. Laws Ann. § 722.301 et seq. (1968).

The juvenile division of the probate court has jurisdiction in proceedings concerning any child under 17.

- (1) Whose parent or other person legally responsible . . . when able to do so, neglects or refuses to provide . . . medical, surgical or other care necessary for his health, morals or well-being. Mich. Comp. Laws Ann. § 712A.2 (1968).

The court may provide such child "with such medical, dental, surgical or other health care, in a local hospital if available or elsewhere, maintaining insofar as possible a local physician-patient relationship" as to the court seems necessary. Mich. Comp. Laws Ann. § 712A.18 (1968).

In *Snyder v. Mason*, 328 Mich. 277, 43 N.W. 2d 849 (1950), the Michigan Supreme Court affirmed an order of the juvenile division of the probate court taking a two-year-old child out of her grandmother's

home and committing her to a children's home, where the mother was dead, the child had a congenital disease and history of poor health and it appeared that the grandmother would not be able to provide proper medical and surgical care. The child had been adjudicated to be "without proper custody or guardianship" under § 712A.2, above.

Michigan authorizes local health boards and local welfare departments to provide family planning services to eligible persons (See Laws Establishing Family Planning Programs, above). In implementing this law, the Health Department *does not* require parental consent for services to minors but the Department of Social Services *does* require parental consent unless the minor receives an assistance grant in his or her own right rather than as a dependent of a grantee. (See Health and Welfare Policies, Eligibility, below).

Footnote:

1. A 1971 case, *Troppe v. Scarf*, 31 Mich. App. 240, 187 N.W. 2d 511 (1971) involved a suit by Mr. and Mrs. John Troppe against a pharmacist who was requested to fill a prescription for birth control pills, but had negligently supplied Mrs. Troppe with tranquilizers instead. After taking the pills for several months, Mrs. Troppe became pregnant and gave birth to a healthy but unwanted child (her eighth); she and her husband sued the pharmacist for lost wages, medical expenses, the pain and anxiety of childbirth, and the economic costs of rearing the child.

The court, basing its decision on general torts law, held that the pharmacist was liable for his negligence, and that damages should be awarded. (This seems to have been the first appellate court passing upon the question of the liability of a pharmacist for negligently dispensing birth control pills.) This decision was reached after an analysis of earlier cases involving negligently performed sterilization procedures where judges had refused to grant plaintiffs' requests for damages to cover the costs of bringing up a healthy but unwanted child, despite the fact that negligence was established. The court cited several later cases, however, which recognized that there was a cause of action for negligent sterilization, e.g. *Custodio v. Bauer*, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463, 27 A.L.R. 3d 884 (1967). (See section on Voluntary Sterilization, below, for fuller discussion of this issue and relevant cases).

The court in *Troppe* recognized that Michigan's public policy is now in favor of contraception (e.g. the state's program of paying for contraceptives as part of its welfare program), and that contraception is now a constitutionally protected right which the state may not infringe by denying protection provided as a matter of course to similar rights.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

In the opinion of the Attorney General, "[t]here is no prohibition in Michigan against voluntary sterilization." *Letter from Attorney General Frank J. Kelley to Harriet F. Pilpel*, January 10, 1972.

The 1971 case of *Troppe v. Scarf* (discussed above

under *Contraception*) involved the measure of damages in an action against a pharmacist who negligently filled a prescription for birth control pills, resulting in the birth of a healthy but unwanted child. Citing decisions in other states involving negligent sterilization procedures, the Court of Appeals of Michigan held that the parents could recover not only for the medical expenses, incapacity and pain and suffering associated with the birth of the child, but also for the expenses of rearing the child.

Michigan has statutes authorizing local health boards to provide family planning services to "medically indigent women" and local welfare departments to refer "recipients of public assistance" to public or private agencies or physicians for family planning services. It is not clear whether "family planning services" as used in these statutes includes voluntary sterilization (See Laws Establishing Family Planning Programs, above). However, the CFPPD survey indicates that the Department of Social Services authorizes referral and payment for voluntary sterilization procedures by local welfare agencies for eligible welfare recipients (See Welfare Policy section).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Michigan Department of Public Health's current policy on family planning consists of a 1965 notice of rule-making filed with the Secretary of State entitled *Family Planning Services*, and the Department's *Plan for 1970-71, Preventive Services Program, Family Planning Sub-Program*. The notice of rule-making sets forth the scope of family planning services, conditions for provision of services (including provision by licensed physicians and appropriately supervised paramedical personnel), a definition of medical indigency, and prohibitions against coercion. The family planning section of the *Plan for 1970-71* sets forth the legal basis for health department family planning activities, defines the need for family planning services, sets forth both long-term objectives and specific objectives for 1970-1971, describes the current status of family planning services in Michigan, describes standards of evaluation for family planning services, and sets forth estimates of current expenditures and necessary costs of future programming.

2. *Eligibility:*¹ The Department of Public Health has established medical indigency as a financial criterion of eligibility for family planning: "A woman may be considered medically indigent if she is receiving funds administered by the welfare department or when the cost of obtaining family planning services from a private physician or family planning clinic is beyond her financial resources or would

cause a hardship on her or her family," according to the notice of rule-making.

Though not mentioned in the written policies cited above, the Department reported in the CFPPD survey that under policy established by the Department, all adults and minors are eligible for family planning services; there are no parental consent or minimum age requirements pertaining to minors. There are no geographical eligibility requirements for family planning services and no patient fees or payments determined by state or local health agencies.

3. *Administration:*² The Bureau of Maternal and Child Health has administrative responsibility for family planning services in the Department of Public Health. Staff assigned to family planning services include: a full-time administrator; a medical director, 25-50 percent time; a nurse consultant, 25-50 percent time; a health education consultant, 25-50 percent time; a full-time account executive; a full-time director of health statistics; a research analyst, 25-50 percent time; a full-time system analyst; one file statistician, less than 10 percent time; one medical social worker, less than 10 percent time; and one full-time secretary. The department performs the following functions in support of family planning: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$338,843 of new MCH funds were allocated to the Department of Public Health for FY 1971 which were federally earmarked for family planning; \$254,000 or 75 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$1,545,513. No information is available on further MCH expenditures for family planning. The Department received a \$100,000 appropriation for family planning from the state legislature for FY 1972. Additional state health agency funds utilized for family planning services include funds allocated to local health departments. No estimate of the expenditure of these funds for family planning is available.

5. *Voluntary Sterilization:* The Department of Public Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Services, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Michigan is contained in Item A-110 Section C of the *Manual of the State Department of Social Services*, dated October 1970. Additional family planning policy is found in Section R400.14 of the Department of Social Services Rules. Section C of the *Manual* cites, and quotes in part, a Michigan statute which states that the state and local departments of social welfare "... may provide ... notice to recipients of public assistance of the availability of advice and treatment in family planning." Section C also includes the following quotations from Section R400.4 of the Rules:

(30) The caseworker may inform the recipient-grantee or spouse of the availability of family planning services only upon request or as an integral part of a comprehensive social study of the total family situation ...

(31) Referral may be made to available resources for advice and treatment only upon the written request of the recipient-grantee or spouse, and only after the family has had time and opportunity to acquire knowledge and understanding of the family planning program.

Section C, however, states that family planning services are needed in the following situations:

In every family in which a parent is unable to properly care for children for reasons of physical or emotional health, or there are indications of serious marital discord, or short periods of time between birth of one or more children out of wedlock, or in which an individual requests family planning services, a service plan is to be developed with the goal of enabling individuals to make an informed decision as to limiting and spacing children and enabling them to carry out this decision.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services *authorizes* local welfare agencies to *refer* eligible public assistance recipients to family planning services. Local welfare agencies are *authorized* but not required to *purchase* medical family planning services for eligible public assistance recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. Reimbursement is also authorized for hospital inpatient services "if necessary." There is no single, standard, statewide rate for the reimbursement of family planning procedures.² According to the CFPPD survey, "the Department of Social Services in conjunction with the Department of Public Health and Blue Cross/Blue Shield, is currently in the process of developing such a rate and schedule." The Department has no contracts or other formal arrangements with providers of services for the provision of family planning.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients and poten-

tial recipients of such assistance, residents of low-income areas and General Assistance recipients are eligible for referral services only.

Paragraph 3 of Section C indicates that "written permission of the client or spouse to provide family planning services is required [when] ... the social worker contacts the provider of service on behalf of the client, sets up an appointment for the client, or otherwise directly participates with the provider of service in order to facilitate the client's use of the service." There are no additional limitations that affect the provision of services to adults. According to Paragraph 1, of Section C, "as a general rule, the worker is to provide family planning information or make a referral for family planning service for a person under 21 only with consent of the parent or guardian. ... The *exception* to this rule is the situation where the person who is under 21 receives a grant in his or her own right. In that case, the person under 21 is considered as any other client." However, Michigan courts have ruled that a minor may consent to medical treatment if he or she is old enough to understand the treatment and it is for his or her benefit. (See Laws on Minors, above).

4. *Administration:*⁴ Responsibility for the administration of the family planning program rests with the Division of Basic Services in the Office of Income Maintenance and Community Social Services. The Director of the Basic Services Division spends less than 10 percent of his time on family planning activities.

5. *Financing:*⁵ The Department of Social Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department authorizes the referral for and the purchase of sterilization procedures by local welfare agencies for eligible welfare recipients.

Footnotes:

1. Information in this section was reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Michigan Medicaid program, family planning services are "Provided for categorically needy persons only; including drugs, supplies, and devices, as provided by qualified family planning clinic, by M.D. or D.O., and by pharmacy. ... Reimbursement on basis of usual and customary fee." The 1970 City University of New York study reported that Michigan in fiscal year 1969 expended \$77,670 for medical family planning services under Title IV-A of the Social Security Act. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)

3. As reported in CFPPD Survey.

4. Ibid.

5. Ibid.

Minnesota

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Minnesota has no law establishing a state family planning program.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* In 1965, the Minnesota legislature deleted the words "for the prevention of conception" from its statute prohibiting the sale or advertising of indecent articles.¹ Minn. Stat. § 617.25 (1966). The legislature enacted at the same time Section 617.251 permitting the sale or distribution of articles or drugs for the prevention of conception only by persons or organizations recognized as dealing primarily with health or welfare.

A 1966 Attorney General's ruling stated that Section 617.251 does not authorize the indiscriminate sale of contraceptives through vending machines. The statute authorized the sale of contraceptives by those dealing primarily in health or welfare, and whether a person or organization qualifies under this provision is essentially a question of fact. It is clear however, that a registered pharmacist would qualify, and that a filling station owner would not. Op. Atty. Gen. 1966, 337 C-3.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Since the amendment of Section 617.25 in 1965, there are none; see above.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. Minn. Stat. § 525.80 (1969). However, a female of 18 or older may marry without parental consent. Minn. Stat. § 517.02 (1969); § 517.08 (Cum. Supp. 1971).

Minnesota has a comprehensive statute regarding health care for minors. S.F. No. 1496, Ch. 544 §§ 144.341 et seq. (1971). Under this law, "any minor who is living separate and apart from his parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing his own financial affairs, regardless of the source or extent of his income, may give effective consent" to medical and health services. § 144.341.

Moreover, any minor who has been married or has borne a child may give effective consent to such services. § 144.342. In addition, any minor may consent to diagnosis and treatment of "pregnancy and condi-

tions associated therewith" and venereal disease. § 144.343.

Medical and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the health professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment. § 144.344.

The consent of a minor who claims that he may give effective consent for the purpose of receiving medical or other health services, but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor. § 144.345.

The health professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in his or her judgment, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient. § 144.346.

Footnote:

1. Section 617.26 (Minn. Stat. 1965) prohibiting the mailing and carrying of obscene matter was formerly applicable to contraceptive supplies because it referred to articles specified in Section 617.25. However, now that Section 617.25 has been amended by striking the reference to articles "for the prevention of conception," the mailing and carrying of such articles is not proscribed by Section 617.26.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The well known case of *Christensen v. Thornby*, 192 Minn. 123, 255 N.W. 620 (1934) involved a suit based on the failure of a vasectomy performed on the husband for reasons of the wife's health. It was argued by the defendant doctor that voluntary sterilization was against public policy and that therefore there could be no recovery. The Minnesota Supreme Court held that a contract to perform a voluntary sterilization was not void as against public policy, nor was the operation illegal. The court noted that they were not "confronted with the question of public policy as applied to sterilization where

no medical necessity is involved. Aside from the few states that have prohibited it, we have found no judicial or legislative announcement of public policy against sterilization.”¹

It was further noted in the opinion that sterilization “does not impair, but frequently improves the health and vigor of the patient. . . . It does not render the patient impotent or unable ‘to fight for the king’ as was the case in mayhem or maiming. . . . We therefore hold that under the circumstances of this case the contract to perform sterilization is not void as against public policy.”

However, damages to compensate for expenses arising from the birth of the child were denied. The court stated:

The purpose of the operation was to save the wife from the hazards to her life which were incident to childbirth. It was not the alleged purpose to save the expense incident to pregnancy and delivery. The wife has survived. Instead of losing his wife, the plaintiff has been blessed with the fatherhood of another child. The expenses alleged are incident to the bearing of a child, and their avoidance is remote from the avowed purposes of the operation. As well might the plaintiff charge defendant with the cost of nurture and education of the child during its minority. 192 Minn. at 126.²

The CFPPD survey indicates that the Department of Public Welfare requires payment for voluntary sterilization procedures by local welfare agencies for public assistance recipients who wish them (See Welfare Policy, Eligibility, below).

Footnotes:

1. At the time this decision was made, in 1934, Connecticut and Kansas had statutes prohibiting voluntary sterilizations. These statutes have since been repealed. Only Utah currently has such a statute which may prohibit voluntary sterilizations which are not medically indicated.
2. But see the recent case of *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W. 2d 511 (1971) (discussed in the Michigan State Profile), where the court held, in an action by parents who had an unwanted child against a pharmacist who negligently filled a prescription for birth control pills, that the cost of rearing the child was a proper element of damages. And in *Coleman v. Garrison*, 281 A. 2d 616 (Del. Super. Ct. 1971), a malpractice action for failure to sterilize, a Delaware lower court held that the cost of support and education of an unwanted child was a proper element of damages.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current written policy on family planning of the Minnesota Department of Health consists of a one page *Statement of Policy on Family Planning*, adopted by the Minnesota State Board of Health in July, 1965. The statement urges public and private organizations and individuals to include in their programs family planning information, counseling and medical services which are acceptable to potential patients. Such

services should be made available to “those who desire a child as well as those who wish to postpone parenthood.” The statement urges that provision should be made for the training of medical and paramedical personnel and for research into population problems. The written policy does not address itself to eligibility and patient fees, administration, or financing.

2. *Eligibility:*¹ The State Department of Health recommends financial eligibility requirements in those areas where the Department is paying physicians directly on a fee for service basis. The upper income limit in these cases is the Federal standard used for Crippled Children's Programs. Other financial, social and geographical eligibility requirements are determined locally. No patient fees or payments are in effect at the state and local level. The Department sets no eligibility requirements with respect to minors.

3. *Administration:*² The Maternal and Child Health Section, Division of Special Services, has administrative responsibility for family planning activities in the State Department of Health. Staff assigned to family planning activities include: the acting Section Chief, 10–25 percent time; one family life education consultant, 25–50 percent time; and one public health representative, full-time. The Department performs the following functions in support of family planning activities: consultation, training, development and distribution of public educational materials, central data processing, grants or contracts to local family planning programs for support of services, and direct payment to private physicians in select areas.

4. *Financing:*³ All \$157,993 of new MCH funds allocated to the State Department of Health for FY 1971 which were federally earmarked for family planning were obligated. The total allocation to the State of nonearmarked MCH funds for FY 1971 was \$752,110. An estimated \$123,662 of these funds were spent for family planning services. The Department receives no specific appropriation for family planning from the state legislature. No other state funds were utilized by the state health agency for family planning services.

5. *Voluntary Sterilization:* The State Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Minnesota is contained in Part VII, Section 3158.05 through 3158.056, dated March 1971, of the *Department of Public Welfare Manual*. Additional family planning policy is found in Chapter 30-450 of the *Regulations of the Department of Public Welfare*. Section 3158.056 of the *Manual* states that "Since family planning services are considered a part of agency program efforts, costs incidental to the giving of such services are to be considered an appropriate public welfare expenditure. Included as justifiable costs are those related to receiving medical examination, medical counseling, drugs, supplies, and devices provided under the direction and supervision of licensed medical practitioners." The objectives of the family planning program as stated in Section 30-451 of the *Regulations* are as follows:

- 21 To promote the health of mothers and children.
- 22 To provide parents and potential parents the opportunity to determine the timing, number and spacing of their children.
- 23 To reduce the incidence of maternal mortality and morbidity.
- 24 To reduce the incidence of infant mortality and morbidity, including prematurity, mental retardation and congenital defects.
- 25 To strengthen family life, including preventing or reducing the incidence of births out-of-wedlock.
- 26 To reduce the incidence of birth out-of-wedlock.

2. *Referral and Purchase Provisions:*¹ Section 30-445 of the *Regulations* states that "Each person for whom family planning services are appropriate, and who is eligible for Services, shall be offered information and assistance with respect to such Services." Under the policy, the Department of Public Welfare also *requires* county welfare departments to *purchase* medical family planning services for these individuals.

The policy, therefore, authorizes reimbursement to hospital outpatient clinics, voluntary agencies, and private physicians. Health departments are not authorized to receive reimbursement under the policy. There is no single, standard, statewide reimbursement rate for medical family planning procedures.² The Department has no contracts or formal arrangements with providers of services for the

provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance, as well as applicants, past recipients, and potential recipients of such assistance are eligible for medical family planning services. Residents of low-income areas and General Assistance recipients are eligible for referral services only.

There are no additional limitations that affect the provision of services to adults or minors. Section 30-453 of the *Regulations* states that family planning "Services shall be offered and made available to any parent or potential parent eligible for public social services who wishes such services."

4. *Administration:*⁴ Responsibility for the administration of the family planning program rests with the Program Development Unit in the Division of Social Services within the Department of Public Welfare. The Program Development Unit has one full-time family planning specialist. The family planning activities of the Unit include the training of local welfare staff, development and distribution of public educational materials, and consultation with local agencies in the development of policy programs.

5. *Financing:*⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *requires* the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Minnesota Medicaid Program, family planning services are "Provided. Including drugs, supplies, and devices. . . . County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/10/70). Basis of reimbursement variable according to provider utilized." The extent of utilization of the Medicaid Program for family planning services is unknown. (For additional information on Medicaid see Federal Law and Policy section of this report.)
3. As reported in CFPPD Survey.
4. Ibid.
5. Ibid.

Mississippi

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Mississippi.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* There is currently no state law specifically restricting or regulating the sale and distribution of contraceptive drugs or appliances since a 1970 amendment deleted reference to "the prevention of conception" from Mississippi's obscenity statute.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found, see above.

4. *Laws Relating to Contraceptive Services to Minors:* Minors are all persons younger than 21 years of age. Miss. Code Ann. § 684 (1957).

However, Mississippi has a comprehensive statute covering medical care of minors. Miss. Code Ann. § 7129-81 et seq. (1971 Cum. Supp.) Any emancipated or married minor may effectively consent to medical and surgical treatment. § 7129-81. "Married" contemplates common law marriage as well as ceremonial. § 7129-82.

An unemancipated minor "of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment" may effectively consent. § 7129-81. This statute codifies the "mature minor rule," adopted in 1928 in Mississippi.¹

Any person standing in *loco parentis*, whether formally serving or not, may consent for the minor to medical and surgical treatment § 7129-81. Emergency permits treatment of a minor without parental consent. § 7129-83.

Any female, married or unmarried, may consent to medical and surgical treatment given in connection with pregnancy or childbirth. § 7129-81.

Any adult may consent for his minor brother or sister. § 7129-81. No person empowered to consent may arbitrarily withhold such consent (§ 7129-81) and where consent cannot be obtained, the court can order medical or surgical treatment for which there is an immediate necessity. § 7129-84.

The statute provides that "[a]ny person acting in good faith and not being placed on inquiry shall be justified in relying on the representation of any

person purporting to give such a consent, including, but not limited to, his identity, his age, his marital status, his emancipation and his relationship to any other person for whom the consent is purportedly given." § 7129-82.

The statute also provides that "[a]ny person authorized and empowered to consent to surgical or medical treatment or procedures for himself or another may also waive the medical privilege for himself or the other person and consent to the disclosure of medical information and the making and delivery of medical or hospital records." § 7129-85.

In addition, Mississippi has a law which provides that any licensed physician who, in the exercise of due care, renders medical care to a minor for treatment of a venereal disease is under no obligation to obtain the consent of or inform a parent or guardian. Miss. Code Ann. § 8893.7 (1971 Cum. Supp.).

A minor child who is not supplied with necessary surgical and medical care becomes "neglected" and statutory penalties "may be imposed against parents who omit the performance of their duty in such respect." See *Eggleston v. Landrum*, 210 Miss. 645, 50 So. 2d 364, 366 (1951).

The Attorney General has expressed the view that there are no laws in Mississippi prohibiting the provision of family planning services to minors. Letter from Attorney General A. F. Sumner to Harriet F. Pilpel, Sept. 1, 1971.

Footnote:

1. *Gulf & Ship Island R.R. v. Sullivan* was a suit for damages against the employer of a 17-year-old boy. The employer's physician had vaccinated the boy to prevent smallpox without obtaining parental consent. Complications resulted from the vaccination. The Mississippi Supreme Court reversed a judgment for the boy, holding that parental consent was not required.

The court stated that the boy

was of sufficient intelligence to understand and appreciate the consequences of the vaccination, usually a very simple operation, resulting in no harm other than a temporary inconvenience.

155 Miss. 1, 10; 119 So. 501, 502 (1928)

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Mississippi has a statute which provides for the compulsory sterilization of certain hospital inmates afflicted with incurable conditions. This statute contains the following provision:

Nothing in this statute shall be construed so as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this state, by a physician or surgeon licensed by this state, which treatment may incidentally involve the nullification or destruction of the reproductive functions. Miss. Code Ann. § 6964 (1953).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed on a person who is otherwise subject to the provisions of the compulsory sterilization law, the procedures prescribed in that law need not be followed although the operation may result in sterilization of the patient.

The Attorney General's office recently stated:

Voluntary sterilization [is] not prohibited if performed on a person legally capable of contracting, or otherwise, if agreed to by the parent, guardian or person in such legal position. Letter from Assistant Attorney General R. Hugo Newcomb, Sr., to Harriet F. Pilpel, September 1, 1971.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* Information on family planning policy of the State Board of Health is from draft guidelines entitled "Family Planning" which were gathered in the 1970 NCFPS letter inquiry of state health departments. The policy has not been verified by the Board since the Board did not respond to the 1971 CFPPD survey.

The draft guidelines describe a family planning program consisting of three components:

The first will be that of public information, education and motivation through every media [sic]. . . . the second . . . will consist of direct patient services in the form of counseling, interpretation, prescribing and providing of supplies, examination and follow-up services . . . the third . . . will be one of providing counseling and the treatment of problems of complications associated with family planning, . . . [e.g., infertility studies, "limited" genetic counseling, and treatment of complications arising from the use of IUD's, oral contraceptives.]

Also:

Medical services for the family planning program will be provided by health officers, clinicians or private physicians depending upon the availability of such personnel in the various counties. Follow-up services will be provided by public health nurses through home visits and health department clinics. Patients will be made to understand that they can return to the health department at any clinic to see the nurse for help or information without waiting for their next regularly scheduled appointment.

Apparently, University of Mississippi Medical Center physicians and private physicians are utilized to

provide family planning services involving use of the intrauterine device where sufficient health department personnel are not available: "Medical fees are paid to private physicians for recheck of IUD and repeat annual Pap smear."

The draft guidelines also describe eligibility and patient fee policies, medical standards, professional qualifications for doctors and nurses providing family planning, family planning mobile unit teams for use in remote areas, and standards for training of physicians, nurses, and "subprofessional workers."

Contraceptive supplies, including "the oral contraceptive pills, intrauterine devices, vaginal creams, foams, . . . and diaphragms will be purchased by the Division of Maternal and Child Health and distributed to the local health departments which have submitted acceptable plans for the administration of family planning clinics."

According to the draft guidelines, "the services provided in this program will be available on a voluntary basis and no coercion will be used to make individuals use them."

2. *Eligibility:* Family planning "services will be available to any family residing in the State of Mississippi without regard to race, religion, nationality, or marital status," according to the draft guidelines cited above. "Referrals will be accepted from any source including the patient's own application. Eligibility for services will be determined through a process of self certification of medical indigency. . . . Any patient presenting herself to the clinics desirous of family planning services will be admitted. No charge will be made to the recipients of these services."

3. *Administration:* Apparently the Division of Maternal and Child Health has primary responsibility for family planning in the Board of Health. No information is available regarding MCH staff assigned to family planning. The Division purchases and distributes family planning supplies according to the draft guidelines cited above.

4. *Financing:*¹ The Board of Health received \$174,528 of new MCH funds for FY 1971 which were federally earmarked for family planning services. The total allocation to the State of nonearmarked MCH funds for FY 1971 was \$878,071. No information is available concerning expenditures from either of these allocations in FY 1971.

However, during FY 1970, the Division of Maternal and Child Health expended \$54,382 for family planning supplies according to the draft guidelines cited above. Although the guidelines do not specify whether this expenditure was made from MCH formula grant funds, the figure represents 6.2 percent of the state's total FY 1970 allocation of formula grant funds, \$877,060.

No other information is available concerning state health agency expenditures for family planning services.

5. *Sterilization*: No information available.

Footnote:

1. Information on federal allocations of MCH funds is from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Mississippi is contained in a two-sentence section on page 1054 of Volume IV of the *Public Welfare Manual*, dated July 1969. These sentences read as follows: "Provide information regarding family planning services. Refer for family planning services those parents who desire more children, wish to limit the number of children in their family, or where another pregnancy would be a health hazard to the mother." The policy contains no statement on the objectives of the family planning programs.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *recommends* that county welfare departments *refer* public assistance recipients to medical family planning resources. The policy *does not authorize the purchase* of medical family planning services.

The Department of Public Welfare reported that family planning services are "available free of charge from local health departments." Private physicians who provide family planning services to foster children are the only medical family planning services providers that the welfare department will reimburse. There is no single, standard, statewide reimbursement rate for medical family planning procedures.² The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral

service. The Department of Public Welfare does not administer a General Assistance program.

There are no additional limitations that affect the provision of services to adults. Parental consent is required for the provision of referral services to all minors except those who are married or emancipated. The minimum age for the provision of referral services without parental consent is 18. Under Mississippi law, however, an unemancipated minor "of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment" may effectively consent.

4. *Administration*:⁴ The Family and Children's Services Unit of the Department of Public Welfare has administrative responsibility for the family planning program.

One Program Coordinator spends less than 10 percent of his or her time on family planning activities. Activities of the Unit are limited to the training of local welfare staff at county and regional levels.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local welfare agencies.

Footnotes:

1. Unless otherwise indicated, information used in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Mississippi Medicaid program, family planning services are "Not Provided." However, this publication is based on data as of January, 1970 and the Mississippi Medicaid program may have been modified since that date. (For additional information on Medicaid see Federal Laws and Policies section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Missouri

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Missouri.¹

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* There is currently no state law in Missouri specifically restricting or regulating the sale or distribution of contraceptive drugs or appliances. In 1967 the Missouri legislature deleted the words "for the prevention of conception" from Missouri's "Comstock law," Mo. Rev. Stat. § 563.300 (1959), and deleted the reference to "articles for preventing conception" from the section authorizing seizure of certain illegal property, Mo. Rev. Stat. § 542.380 (3).

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found; see above.

4. *Laws Relating to Contraceptive Services to Minors:* A minor is any person younger than 21 years. Mo. Rev. Stat. § 475.010 (1956).

A minor can consent to examination, treatment, hospitalization, and medical and surgical care for venereal disease and for pregnancy (excluding abortion). The physician may, with or without the consent of the minor patient, notify the minor's parents if the minor has venereal disease or is pregnant. Mo. Rev. Stat. §§ 431.061, 431.062 (1971 Cum. Supp.)

Any lawfully married minor and any minor parent or legal custodian of a child may contract for and consent to medical and surgical treatment for himself, his spouse, his child or any child in his legal custody. Mo. Rev. Stat. § 431.065 (1971 Cum. Supp.)

Under Missouri Law males younger than 21 and females younger than 18 need written parental consent in order to be issued a marriage license.² Mo. Rev. Stat. § 451.090 (1952). The same statute provides that persons younger than 15 may not be issued a marriage license unless a court orders its issuance "for good cause". The Attorney General has stated that, in addition to a court order, parental consent is also needed for issuance of a license to minors younger than 15. Op. Atty. Gen. No. 92, 11-14-61.

In *Walker v. Walker*, 316 Ill. App. 251, 44 N.E. 2d 937 (1942), an Illinois court held that under Missouri law parental consent is not necessary to the validity of a minor's marriage. In *State v. Bittick*, 103

Mo. 183, 15 S.W. 325 (1891), the Missouri Supreme Court recognized that the common-law age of consent to marriage (12 for females and 14 for males) was still in effect in Missouri since no statute expressly nullified it.³

Though we have found no cases on the question of an emancipated minor consenting to his own medical care, Missouri courts do view emancipation as an extinguishment of parental rights and duties, *Swenson v. Swenson*, 241 Mo. App. 21, 227 S.W. 2d 103, 20 A.L.R. 2d 1409 (1950); *Brosius v. Barker*, 154 Mo. App. 657, 136 S.W. 18 (1911); and may be presumed to follow the general pattern of permitting an emancipated minor to consent to his own medical care without the necessity of parental consent.

Emancipation may be express, or implied from the parent's conduct. Implied emancipation occurs when a parent, by his or her acts or conduct impliedly consents that the child may make its own way in the world, or when a parent acquiesces in his or her child's working for others, with the child receiving its own pay therefor, and spending the money as it pleases. *Wurth v. Wurth*, 322 S.W. 2d 745 (1959); *Brosius v. Barker*, *supra*; *McMorrow v. Dowell*, 116 Mo. App. 289, 90 S.W. 728 (1905); *Ream v. Watkins*, 27 Mo. 516, 72 Am. Dec. 283 (1858).

Some examples of how the Missouri courts view emancipation in specific situations follow:

In *Wurth v. Wurth*, *supra*, a minor of 20 who went to work at 19, retained her wages and paid her parents for room and board, paid for her clothing, her medical bills, and in general all her other needs, was held emancipated. (The case involved the minor's attempt to sue her father for injuries she sustained in an auto accident when the father was driving).

In *Swenson v. Swenson*, *supra*, it was held that when a minor enlists in the military, he is emancipated so long as the military service continues. Parental consent to the minor's enlistment is not necessary to effect the emancipation. *Green v. Green*, 234 S.W. 2d 350 (1950).

In *Brosius v. Barker*, *supra*, the court defined complete emancipation as an "entire surrender of all the rights to the care, custody and earnings of the child, as well as a renunciation of parental duties. And the test to be applied is that of preservation or destruction of the parental and filial relations." 136

S.W. 18, 19. (In this case a 20 year old minor who left home, moved to another state and found a job became ill with typhoid fever. The doctor who treated him then sued the minor's father for payment of medical services and hospital fees. The father claimed that the son was emancipated and that therefore he, the father, was not liable for the son's medical bills. The court held the evidence of emancipation sufficient to submit to a jury for determination.)

In *Spurgeon v. Missouri State Bank*, 151 F. 2d 702 (1945), an 18-year-old minor who left home with his parents' consent "to make his way in the world" and moved to another state, where he found employment and lived for three months until being drafted into the army, was held emancipated for the purpose of acquiring a domicile of his own and suing in the federal courts on the basis of that domicile.

In *Ream v. Watkins*, a minor who was allowed by his father to leave home and work and shift for himself was held emancipated so as to enable him to maintain an action in his own name to recover the value of services rendered by him.

McMorrow v. Dowell, *supra*, involved a minor who when she was four years old, was taken by her parent to live and work in the home of another; she lived there until grown with the expectation of being paid for her services. The court held that the parent's lack of objection to this arrangement and lack of demand over the years on the alleged employer for the child's salary was "evidence of emancipation of the minor."

In *Evans v. Kansas City Bridge Co.*, 213 Mo. App. 101, 247 S.W. 213 (1923), a minor whose parents were divorced and who after his mother's death was raised by his aunt was held emancipated from his father's control since his father had not exercised parental supervision nor provided support since the boy was three years old. (The father was seeking to recover his deceased son's wages from the boy's employer. The court found that this boy had been hired on the assumption that he was emancipated, and that the father, while his son was alive, did nothing to indicate that he had *not* relinquished his claim to his son's wages.)

In *Curry v. Maxson*, 318 F. Supp. 842 (1970), the court held that even though a minor left his parents in Missouri and took an apartment and worked in Kansas, registered his car in Kansas and intended to establish his own residence in Kansas, under Missouri law he was not emancipated since his parents did not expressly or impliedly consent to emancipate him. This was manifested by his parents' continued support of him, such as paying his medical bills, and by the minor's mother acting as his "next friend" in bringing this action. (This case involved a suit by the minor against a physician for

the physician's alleged negligent treatment of the minor's acne. Since the minor was held unemancipated, he could not obtain citizenship in Kansas, allowing him to use the federal courts to sue the physician who resided in Missouri.)

In *Beebe v. Kansas City*, 223 Mo. App. 642, 17 S.W. 2d (1929), a 15-year-old minor who lived at home, working at odd jobs, was held unemancipated. The court held that the consent of a parent to his minor child working and receiving pay for himself "is but a license, revocable at will as between him and the child" and that the evidence in this case showed merely a revocable license rather than emancipation.

We have found no cases indicating whether Missouri courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies or whether Missouri courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors" section. However, the health department indicated in the CFPPD survey that it recommends that minors be eligible for family planning without parental consent if they "are emancipated" or if they have ever been married or pregnant (See "Health Policy," "Eligibility," below).

Under Missouri law, the juvenile court has jurisdiction over any child who is alleged to be neglected in that his parents "neglect or refuse to provide proper . . . medical, surgical or other care necessary for his well being. . . ." Mo. Rev. Stat. § 211.031 (1962). The court may order the child to be examined and treated by a physician. § 211.181. In *Morrison v. State*, 252 S.W. 2d 97 (1952) the parents of a 12-day-old infant refused on religious grounds to consent to a blood transfusion for their child despite the fact that competent medical opinion was that the transfusion was necessary to save the child's life. The court adjudicated the child "dependent," made her a ward of the court and ordered the transfusion.

Under § 199.240, "No person committed to the Missouri state chest hospital [for tuberculosis] . . . shall be required to submit to medical or surgical treatment . . . if a minor, without the consent of a parent or next of kin." Mo. Rev. State. § 199.240 (1972).

Footnotes:

1. In 1967, before the legislature amended § 563.300, the Attorney General was asked to rule whether § 563.300 prohibited the Department of Welfare from disseminating information to welfare recipients concerning "planned parenthood." The Attorney General said that the statute should be construed strictly so as to prohibit only the acts mentioned therein, and therefore would not prohibit the verbal dissemination of information on "planned parenthood."

2. "No marriage . . . shall be recognized as valid unless . . . [a] marriage license has been previously obtained." Mo. Rev. Stat. § 451.040 (1952).
3. The statute in force in 1891 was similar to § 451.090, now in effect.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

A recent Missouri Attorney General's opinion, withdrawing a prior 1946 opinion, concludes that although there is a general law on mayhem, it does not apply to voluntary sterilization and that "Missouri law does not prohibit the performance of voluntary contraceptive human sterilization by licensed physicians." Op. Atty. Gen. No. 393, August 19, 1971.

The CFPPD survey indicates that the Division of Welfare recommends the referral and payment for voluntary sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them. (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Missouri Division of Health has no written policy on family planning. However, in the CFPPD survey, the Division reported the following unwritten policy: "The Missouri Division of Health has an *immediate goal*: to give support and consultative guidance for establishment of family planning services within all interested local health units. *Long range goal*: to aid in support and development of a coordinated statewide family planning program. It is the Division of Health's policy to reimburse local health units on a clinic session basis where quantity and quality of services rendered conform to acceptable standards."

2. *Eligibility:*¹ The Division of Health recommends that all categories of adults be considered eligible for family planning services and that minors who are or have been married or pregnant, and emancipated minors be considered eligible without parental consent. All other minors require parental consent under the recommended policy. The Division recommends that no fee structure be utilized "except where local situations require it or where it would be inconvenient not to utilize fees." No financial or geographical eligibility requirements are recommended or established by state health policy.

3. *Administration:*² The Bureau of Maternal and Child Health has administrative responsibility for family planning activities in the Division of Health. Staff assigned to family planning activities include: one physician, 25-50 percent time; and two public

health nurses, 25-50 percent time. The Division performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ The Division of Health received \$208,733 of new MCH funds in FY 1971 which were federally earmarked for family planning. \$195,000, or 93.4 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$865,304. None of these funds were spent for family planning services. The Division received no specific appropriation for family planning from the state legislature. The state health agency utilized no other state funds for family planning services.

5. *Voluntary Sterilization:* The Division of Health has no written policy with regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Missouri is contained in *Public Assistance Manual*, Volume II, Section XIX, pages 41 and 42 and in Chapter VII, pages 1 thru 4, of the *Family Service Manual* of the Division of Welfare in the State Department of Public Health and Welfare. Page 41 of the *Public Assistance Manual* was issued May 1969, and page 42 was issued in February 1970. Subparagraph 1 on page 41 reads as follows: "As is the case with other local health and welfare services, the caseworker shall make known to all mothers in ADC and GR households the availability of family planning services in their community." Chapter VII of the *Services Manual* contains the following statement: "Those interested in population control believe that holding families together and limiting the number of children in keeping with parental ability to provide for them will substantially reduce the numbers of children and adults requiring assistance payments." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Division of Welfare *requires* local welfare

agencies to *refer* eligible public assistance recipients to medical family planning services. The Division's referral policy is described in detail on page 3 in Chapter VII of the Manual and reads as follows:

The worker in making a referral to the above listed family planning providing agencies will write a letter to the agency including the following information:

1. The economic and social status of the family including: income, regularity of employment of the father, social status of the family in the community whether low, middle or upper class.
2. Religious background of the parents, which would include specifying the religious sect, and their conviction about their religion.
3. Past pregnancy history such as number of live births, number of spontaneous abortions, etc.
4. Menstrual history of the mother including beginning of the menstrual cycle, duration of the menstrual period, and intervals between periods.
5. Medical history of the mother, including:
 - a. Measles.
 - b. RH factor, if known.
 - c. Diabetes.
 - d. Heart trouble.
 - e. Liver trouble.
 - f. Anemic or not.
 - g. Use of narcotics or LSD, if known.

The Division *recommends* that local welfare agencies *purchase* medical family planning services for eligible public assistance recipients.

The policy authorizes reimbursements to hospital outpatient clinics and private physicians. The Division reported that health departments and voluntary agencies are not authorized to receive reimbursement. However, page 42 of Section XIX of the *Public Assistance Manual* states: "Since clinics operated by a Planned Parenthood Association or similar agency are not eligible to participate as clinics under Title XIX program, any charges for service from such clinics would be included in the budget as 'medical expense.'" The Division reported that there is a standard, statewide reimbursement rate for medical family planning procedures.² The reimbursement rates are as follows:

	GP	SPECIALIST
Initial medical examination	\$ 9.00	\$13.00
Annual medical examination	9.00	13.00
IUD insertion	10.00	13.00
One cycle of oral contraceptives	Average \$2.35	

The Division has no contracts or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients and potential recipients of such assistance are eligible for

referral services only. Residents of model cities areas and General Assistance recipients are, however, eligible for medical services.

The policy manuals authorize the provision of family planning information "to parents of children receiving ADC, and other forms of assistance payment." The manuals consistently use the words "parents" and "mothers" in describing family planning activities and responsibilities. Thus, the policy appears to limit family planning services to mothers. The policy contains no statement on services to minors, but the division reported that parental consent is required for all minors except those that are married or emancipated; and these, it would appear must be mothers in order to receive family planning services.

Though the response from the CFPPD survey states that there are no restrictions on eligibility, the policy manuals would seem to indicate that parenthood is required.

4. *Administration:*⁴ Administrative responsibility for the welfare family planning program is not assigned to any particular subdivision or unit in the Division of Welfare. No staff are assigned either full or part-time to family planning but activities of the Division include the training of local welfare staff and the development and distribution of educational materials.

5. *Financing:*⁵ The Department of Public Health and Welfare received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Division of Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Division *recommends* the *referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Missouri Medicaid program family planning services are "Provided. Limited to physician's services and prescribed drugs listed in drug formulary. Birth control devices not included. Reimbursement on variable basis according to provider utilized." The 1970 City University of New York study reported that \$55,070 was expended for contraceptive drugs and devices by the Missouri Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures were \$75,000. (For additional information on Medicaid see Federal Laws and Policies section of this report).
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Montana

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Montana.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Montana has several provisions in its obscenity laws which relate to contraceptives and prophylactics: Section 94-3616 prohibits the sale, including sale by vending machine, or giving away of contraceptives, prophylactics and articles for preventing venereal disease. An exception is made in the statute exempting regularly licensed practitioners of medicine, osteopathy, or other licensed persons practicing other healing arts, registered pharmacists, and wholesale drug jobbers or manufacturers who sell to retail stores only. Mont. Rev. Codes Ann. (1947).

Despite the provision in § 94-3616 exempting physicians and medical practitioners from the ban on distribution of contraceptives, Montana has another statute that prohibits medical practitioners from engaging "directly or indirectly in the dispensing of drugs"; there are five exceptions to this prohibition: dispensation of drugs occasionally, dispensation of drug samples, furnishing a patient any drug in an emergency, dispensation of a drug where there is no community pharmacy available, administration of a drug in a unit dose. Mont. Rev. Codes Ann. § 27-903 (1947).

In a recent opinion, the Attorney General stated that oral contraceptive pills are "drugs" within the meaning of § 27-903, and that doctors in general are prohibited from dispensing such drugs: "Only pharmacists may lawfully dispense oral contraceptives in the state of Montana." Op. Atty. Gen. Nov. 23, 1971. (*Letter from Robert L. Woodahl, Attorney General to Robert L. Deschamps, III*).

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Section 94-3609 prohibits advertising any medicine or means for the prevention of conception. Mont. Rev. Codes Ann. (1947).

Section 94-3617 prohibits the display of prophylactics or contraceptives in show windows, on the streets or in public places; however a licensed pharmacist may display them in his place of business. This section also forbids all types of advertising of

contraceptives or prophylactics. An exception in the statute, however, exempts medical and pharmaceutical professional publications; interstate publications where the advertising does not violate federal laws or Post Office regulations; and furnishing qualified purchasers within the store of a licensed pharmacist, information concerning the proper use of contraceptives or prophylactics.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 19. Mont. Rev. Codes Ann. § 64-101 (1971 Cum. Supp.).

A minor who is or professes to be married, pregnant or afflicted with a venereal disease, can consent to medical or surgical treatment and no other person's consent is necessary. Mont. Rev. Codes Ann. § 69-6101 (1970). A treating physician may but need not inform the spouse, parent or guardian as to treatment given or needed, even over express refusal of the minor patient. § 69-6102. The law applies whether or not the professed suspicions of pregnancy or venereal disease are medically substantiated. § 69-6103. Any consent given shall not be valid if, following a delivery or other termination of a pregnancy, it is determined that surgery not directly connected with the pregnancy is required or requested. § 69-6104. The physician providing medical or surgical care under this law shall incur no civil or criminal liability except for negligence. § 69-6105.

A minor can consent to psychiatric or psychological counseling by a physician or psychologist where there is an emergency and the consent of the spouse, parent or guardian cannot be obtained within a reasonable time. Mont. Rev. Codes Ann. § 69-6106 (1971 Cum. Supp.).

Persons who are 19 years of age may consent to marriage. Those who are younger than 19 need parental consent and court approval in order to be issued a marriage license. Mont. Rev. Codes Ann. § 48-143 (1971 Cum. Supp.). In *Cross v. Cross*, 110 Mont. 300, 102 P. 2d 829 (1940), a Montana court, interpreting an Idaho statute which it said was essentially similar to Montana's statute on the subject, held that the requirement of parental consent is applicable only to the issuance of a license and simply a directive to the clerk who issues the license; the lack of such consent does not affect the validity of the marriage. This was confirmed in *Teague v. Allred*, 119 Mont. 193, 173 P. 2d 117 (1946).

Parental authority ceases upon the child's attaining majority, upon the marriage of a child, or upon appointment by a court of a guardian of a child. Mont. Rev. Codes Ann. § 61-112 (1970). A Montana statute provides another means of emancipating a child from parental authority: "The parent . . . may relinquish to the child the right of controlling him and receiving his earnings. Abandonment by the parent is presumptive evidence of such relinquishment." Mont. Rev. Code § 61-119 (1970).

Although we have found no cases or Attorney General opinions on the question of an emancipated minor consenting to his or her own medical care, a Montana court has stated that emancipation serves to release a child from parental control, *Hoskins v. White*, 13 Mont. 70, 32 P. 163 (1893), and thus it may be presumed that Montana follows the general pattern of permitting an emancipated minor to consent to his or her own medical care without the necessity of parental consent.

We have found no cases indicating whether Montana courts follow the general pattern of permitting medical treatment (other than psychiatric or psychological counseling) for minors without parental consent in emergencies, or whether Montana courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors." However, the health department indicated in the CFPPD survey that minors are eligible for family planning services without parental consent if they are emancipated, or have been married or pregnant, or profess to be pregnant currently or have venereal disease.

Under Montana law it is a crime for a person who has a child younger than 16 dependent upon him or her for care or support to "willfully omit, without lawful excuse, to provide necessary and proper . . . medical care for such child. . . ." Mont. Rev. Codes Ann. § 94-304 (1969).

In civil proceedings a child who is adjudicated "neglected" comes under the jurisdiction of the court, and the court may make such disposition of the child as seems best for the child's social and physical welfare, including permitting the child to remain with its parents. Mont. Rev. Codes Ann. § 10-501 ff. (1968). A "neglected" child is defined as any child of 16 or younger "who has no proper parental care or guardianship." § 10-501. In *In re Vikse*, 147 Mont. 417, 413 P. 2d 876, 877 (1966) the court held that under § 10-501, neglect described "a parental failure to exercise the degree of care demanded by the family circumstances. It concerns disregard of parental duty, whether intentional or unintentional."

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts

the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Montana has a statute providing for the sterilization of certain persons who "might be expected either (1) to transmit mental deficiencies to [their] offspring, or (2) be unable to adequately care for or rear such offspring." This statute contains the following provision:

However, nothing in this act shall be deemed to prohibit a physician, at the request of the applicant, his or her parent, guardian or custodian, from performing a sterilization procedure on such applicant for purely medical as distinguished from eugenical reasons. Mont. Rev. Codes Ann. § 69-6406 (1970).

This language makes it clear that a sterilization operation may legally be performed on the persons covered by the statute for medical reasons and that where such reasons are present the procedures prescribed in the sterilization law need not be followed.

Individual programs have funds in their budgets to pay for voluntary sterilization services, referrals and counseling. (See Health Policy, Sterilization, below).

The CFPPD survey indicates that the Department of Public Welfare recommends the referral and payment for voluntary sterilization procedures by local welfare agencies for eligible welfare recipients who wish them (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Montana State Board of Health adopted a *Policy Statement on Family Planning* on January 9, 1965. The policy states: "the Montana State Board of Health endorses the principle of family planning and urges that proper information and medical assistance be provided all persons who desire to have a child as well as to people who would like to postpone this event." Medical assistance in family planning should be provided by physicians or by programs "conducted with the support of physicians and should preserve . . . individual freedom of decision. . . ." The policy statement notes that "the Montana State Board of Health believes . . . that payment for these services for the indigent and medically indigent is a proper and reasonable use of public funds."

2. *Eligibility:* There is no written state health agency policy recommending or establishing eligibility requirements for family planning. However, the State Department of Health indicated in the CFPPD survey that, apart from official health agency policy, the following eligibility requirements are applicable to minors: Minors who are or have ever been married or pregnant, or emancipated minors, are eligible for

family planning services without parental consent. Other sexually active minors are eligible without parental consent "only if they profess to have venereal disease or are pregnant." No other eligibility requirements or patient fees were mentioned by the state health agency in the survey.

3. *Administration*:¹ The Division of Child Health Services has administrative responsibility for family planning services in the State Department of Health. At the state level six professional staff are assigned to family planning activities as follows: one medical doctor, 25-50 percent time; two MCH nurses, 10-25 percent time; one MCH nutritionist, less than 10 percent time; and two health educators, 10-25 percent time. The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; purchase or provisions of supplies, equipment or other materials to local family planning programs; grants to local family planning programs; development of new programs; and integration of family planning and maternal and child health programs.

4. *Financing*:² All new MCH funds allocated to Montana for FY 1971 which were federally earmarked for family planning were obligated; this amounted to \$14,070. The total allocation to the state of non-earmarked MCH funds for FY 1971 was \$212,615. An estimated \$25,192 of these funds were spent for family planning services. The State Department of Health received no specific appropriation for family planning from the state legislature. Apart from MCH funds the state health agency utilized an unspecified amount of general funds from the Department's budget as matching for federal family planning funds.

5. *Voluntary Sterilization*:³ The State Department of Health has no written policy in regard to sterilization but individual programs have funds in their budgets to purchase voluntary sterilization services, referrals and counseling.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
3. As reported in CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Montana is contained in Section 2950 of Volume II of the *State Department*

of Public Welfare Manual, dated July 1969. The policy states: "It is required of county workers that recipients of assistance be provided with information about family planning services. Educational and contraceptive services are available throughout the State through the State Board of Health and our State medical assistance plan." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* family planning services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. There is no single, standard, statewide reimbursement rate for medical family planning procedures.² The Department, however, reported that it does have contracts and/or other formal arrangements with providers of medical family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. General Assistance recipients are eligible for medical family planning services.

Section 2960 states that family planning "services are available to those persons desiring them, regardless of age, marital status or parenthood," but this section also provides that "In instances where a child is using the service and is under legal age, voluntary consent must include parental consent or consent of person having custody of the child." The Department reported that parental consent is required for all minors except those that are married or emancipated.

4. *Administration*:⁴ Responsibility for the administration of the family planning program rests with the Division of Social Services in the Department of Public Welfare. No staff are assigned either full- or part-time to family planning, but activities include the training of local welfare staff, the development and distribution of public educational materials, and cooperative programs with the State Board of Health.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary ster-

ilization, but the CFPPD survey indicated that the Department *recommends* the *referral* for the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in these sections was reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Montana Medicaid program for family planning services are "Provided. Upon recommendation of family physician. Reimbursement on basis of customary charges that are reasonable." The extent of utilization of the Medicaid program for family planning services is unknown. For additional information on Medicaid see Federal Laws and Policies section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Nebraska

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Nebraska.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Nebraska has a statute which prohibits the sale or distribution of "any secret nostrum, drug, or medicine for the purpose of preventing conception [or] procuring abortion or miscarriage." Neb. Rev. Stat. § 28-423 (1964). In a 1965 case, the Supreme Court of Nebraska held that the statute is not violated if the nostrum, drug or medicine is not "secret." *State v. Lauritsen*, 178 Neb. 230, 132 N.W. 2d 379 (1965).¹

Since most contraceptives are not "secret" (those sold and distributed in Nebraska² tend to be the same types commonly available anywhere), § 28-423 would seem to have little inhibiting effect upon their sale or distribution. Nebraska state and local health and welfare departments currently provide family planning services, including payment for devices, indicating that they do not regard those contraceptives which are distributed or prescribed as prohibited "secret" drugs, and indicating also that there is a state policy in favor of distribution of contraceptives.

Nebraska's Prophylactic Control Act regulates devices for the prevention of venereal disease. Neb. Rev. Stat. §§ 71-1104 to 71-1114 (1967). This law prohibits the sale (including the sale by vending machine) or giving away of prophylactics, except by a licensee under this statute. An exception exempts physicians in the regular practice of their profession who dispense prophylactics to their patients.

Under the statute, there are two kinds of licenses:

a) *Wholesale*—licensees may sell in the usual wholesale manner but only to other licensees under this statute. A manufacturer who has a wholesale license must follow the same rule and sell only to those holding licenses under the statute. An exception provides that wholesalers may sell to physicians or physicians' patients upon a physician's written and signed order.

b) *Retail*—a retail license may be issued only to pharmacies; they may sell to physicians or upon their order; to married persons; or to persons over 18.

Sales must be confined to the licensee's place of business but delivery may be made to purchasers.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Nebraska's statute on contraceptives also prohibits the advertising of such "secret" nostrums and drugs for the prevention of conception. Neb. Rev. Stat. § 28-423 (1964). An exception is made for teaching in medical colleges or publication of standard medical books. (See discussion of "secret" nostrums and drugs under 2, above).

The Prophylactic Control Act (see above) prohibits the display of prophylactics in show windows, upon the streets or any public place. An exception permits a licensee to display prophylactics in his place of business.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 20, but in case any person marries under the age of 20 his minority ends. Neb. Rev. Stat. § 38-101 (1969).

No reported cases were found in Nebraska dealing with medical care for minors.

In the absence of case law, it is not clear to what extent Nebraska courts would follow the general pattern of permitting treatment for minors without parental consent in emergencies and where the minors are "emancipated" or whether Nebraska would accept the "mature minor doctrine" referred to in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

In a case involving an (adult) anesthetized patient unable to consent, the Nebraska Supreme Court held that the surgeon was justified by the emergency in proceeding without consent. *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929).

In Nebraska, a minor is emancipated when his parents voluntarily surrender the right to custody and control (see *Adams & Burke Co. v. Cook*, 82 Neb. 684, 118 N.W. 662 (1908)) or lose that right by abandonment or neglect (see *Thompson v. Chicago, M & St. P. Ry. Co.*, 104 Fed. 845 (Cir. Ct., D. Nebraska (1900))). See moreover, the broad definition of emancipation contained in the venereal disease statute quoted below, which might be used as a guide by a court in deciding when a minor may receive birth control services without parental consent.

It is a misdemeanor for a retail licensee to sell prophylactics (defined as any device, appliance or medicinal agent used in the prevention of venereal disease) to anyone but a married person or a person over 18 years of age, except that sales to physicians or upon their order are permitted. Neb. Rev. Stat. § 71-1112 (1967).

The Nebraska Department of Public Welfare requires that birth control information and services be made available to all recipients of federally-aided public assistance "without regard to marital status, age or sex," and the policy does not indicate that parental consent is required for minors (See Welfare Policy, Eligibility, below).

Nebraska has a statute authorizing examination and treatment of minors for venereal disease. If a minor appears in any clinic, hospital, physician's office or other medical facility and relates a history of sexual contact or exposure to venereal disease or states that he may be suffering from a venereal disease, the state or local director of health or his agent or the attending physician may cause such minor to be examined. If the minor requires treatment and consents in writing, he may be treated. Neb. Rev. Stat. § 71-1119 (1967). In neither case is parental consent required. The physician, clinic or health department examining and treating any child under 16 years of age for a venereal disease must write to the parent or guardian requesting them to come in to discuss the child's health program. A similar letter must be sent to parents of children over 16 years of age who have not become emancipated from parental authority. Neb. Rev. Stat. § 71-1120 (1967).

The statute provides that, for the purpose of these venereal disease Sections (71-1119 and 71-1120), a child shall be considered emancipated if the child: 1) is a married male and has established his own residence; 2) lives and works away from parental control, particularly if the parents live in another jurisdiction or if the whereabouts of the parents are unknown to the child; 3) is a married woman; 4) holds the franchise; or 5) is found under such other combination of circumstances which indicate that the parents have abandoned their parental rights and duties and no one else has acquired such rights or duties through legal process or operation of law. Nebraska also has a statute which provides that a child "whose parent, guardian or custodian neglects or refuses, when able to do so, to provide necessary medical, surgical, institutional or hospital care for such child" shall be deemed neglected. Neb. Rev. Stat. § 43-504 (4) (1952). When the health or condition of such a child require it, the court may cause the child to be placed in a public or private hospital or institution for treatment or special care. Neb. Rev. Stat. § 43-208 (1952).

Footnotes:

1. In this case the defendant was convicted of selling alkaloid of ergot for the purpose of procuring a miscarriage. The court reversed his conviction on the grounds that that was not a secret drug and therefore the statute was not violated.
2. See T. R. Pansing, "Criminal Law—Contraceptive Statute—Prophylactic Control Act—Implied Repeal—Implied Exception," 19 *Nebraska Law Bulletin* 35 (1940).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The CFPPD survey indicates that the Department of Public Welfare leaves the question of referral for voluntary sterilization procedures to the option of local welfare agencies, and that these agencies are authorized to pay for voluntary sterilization procedures for eligible public assistance recipients (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Nebraska Department of Health has no official written policy on family planning.
2. *Eligibility:*¹ Financial and social eligibility requirements for family planning services, as well as patient fees or payments, are determined by local health agencies. There are no state or local geographical eligibility requirements in effect.
3. *Administration:*² The Division of Maternal and Child Health has administrative responsibility for family planning activities in the Department of Health. Staff assigned to family planning activities include the MCH Director and a health educator who devote 25-50 percent of their time to family planning. The Department carries out the following functions in support of family planning activities: consultation; development and distribution of public educational materials, grants or contracts to local family planning programs for support of services, and development of a state plan.
4. *Financing:*³ \$57,018 of new MCH funds were allocated to the Department of Health in FY 1971 which were federally earmarked for family planning; \$41,494, or 72.7 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$289,361. No estimate of expenditures of these funds for family planning is available. The Department received no specific appropriation for family planning from the state legislature. No other state funds were utilized by the state health agency for family planning.

5. *Voluntary Sterilization*: The Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Nebraska is contained in Sections 1520, 1536, 1771, and 6532 of the *Department of Public Welfare State Plan and Manual*. Except for Section 6532 which was revised on July 1, 1970, all sections were revised on September 1, 1970. Section 1536 defines family planning services as "a range of services directed toward the needs of each family in the areas of family relationships, role acceptance and responsibility, recreation, planning for the future, individual self respect, and birth control." Subsection 1536.04 states that birth control "services *must* be provided upon request of the recipient when recommended by a physician." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients.

The policy authorizes reimbursements to voluntary agencies and private physicians. Hospital outpatient clinics and health departments are not authorized to receive reimbursement. There is no single, standard statewide reimbursement rate for medical family planning procedures.² The Welfare Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services

only. General Assistance recipients are eligible for medical family planning services.

According to subsection 1536.04, "birth control planning for married couples must involve both the husband and wife and decisions made should be by them." There are no stated additional limitations that would affect the provision of services to adults or minors. Section 6532 provides that "birth control information and services shall be made available to all appropriate recipients without regard to marital status, age or sex, and shall include medical, social and educational services."

4. *Administration*:⁴ The Division of Social Services and the Division of Medical Services in the Department of Public Welfare share administrative responsibility for the welfare family planning program. One individual in each of these divisions spends less than 10 percent of his time in family planning activities. Family planning activities of the two divisions are confined to the training of local welfare staff.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriations for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local welfare agencies and these agencies are also authorized to pay for sterilization procedures for eligible public assistance recipients.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Nebraska Medicaid program family planning services are "Provided. Physicians' services, drugs, supplies and devices. No payment to family planning organization for consultation or for materials dispensed. . . . Reimbursement to physicians on basis of usual, customary, and reasonable charge." The 1970 City University of New York study reported that \$13,800 was expended for contraceptive drugs and devices by the Nebraska Medicaid and Title IV-A programs in Fiscal Year 1969. (For additional information on Medicaid, see Federal Laws and Policies section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Nevada

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* In 1971, Nevada enacted its Family Planning Services and Population Research Law. Assembly Bill No. 662, amending Chapter 439 of the Nevada Revised Statutes (effective July 1, 1971.) This statute's stated purpose is to make family planning services available to all persons desiring such services, and to set up a comprehensive family planning program including research, planning and coordination of existing and future programs and needs. The statute establishes a Bureau of Population Affairs within the Health Division of the Department of Health, Welfare and Rehabilitation to administer and coordinate Nevada's family planning and population affairs, and directs the Secretary of the Bureau of Population Affairs to draw up a five year plan for submission to the Welfare Division setting forth plans for (1) the extension of family planning services to all desiring such services, (2) family planning and population research programs, and (3) training of the necessary manpower for the programs. The Health Division is authorized under the statute to make applications to the U.S. Department of Health, Education, and Welfare for funding under P.L. 91-572 (Family Planning Services and Research Act of 1970).

Nevada has in addition laws authorizing the State Departments of Health and Welfare to establish family planning programs. Nev. Rev. Stat. § 422.235 (1967) authorizes the Welfare division to conduct a family planning service, including the dispensing of information and the distribution of literature, and referrals, in any county of the state. Section 442.080 authorizes the Health Division to provide medical services, appliances, drugs and information for birth control, to the extent that funds are available.¹

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.²

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Nevada's statute prohibiting advertising of articles for the prevention of conception was repealed in 1967.³ Thus there is now no state law specifically restricting or regulating the display or advertising of contraceptive drugs or appliances.

4. *Laws relating to Contraceptive Services to Minors:* Males at 21 and females at 18 are capable of entering into contracts and are for all purposes considered of lawful age. Nev. Rev. Stat. § 129.010 (1969). Emancipated and lawfully married minors can effectively consent to medical and surgical care. Nev. Rev. Stat. § 129.030 (1969). Subsequent judgment of annulment or divorce does not deprive such person of his adult status once attained. *Ibid.*

Males of 18 and females of 16 may be joined in marriage, but males younger than 21 and females younger than 18 need parental consent. Nev. Rev. Stat. § 122.020 (1969). Notwithstanding § 122.020 a court may authorize the marriage of females younger than 16 or males younger than 18 upon the written consent of the parents or guardian of such person. Nev. Rev. Stat. § 122.025 (1969). Marriages made by persons who are underage, or who lack the necessary parental consent, are nonetheless valid and binding. 4 Nev. Stat. §§ 125.310, 125.320 (1967).

What constitutes emancipation, according to the Nevada court in *Goldsworthy v. Johnson*, 45 Nev. 355, 204 Pac. 505 (1922), depends upon the facts and circumstances of each particular case. The court stated that emancipation may be manifested by a failure of the father to assert his right to receive his child's earnings and by acquiescing for a sufficient length of time in a course of conduct on the part of the child which shows the father's intention to emancipate the child.

The concept of emancipation for a specific purpose was raised in *Warren v. De Long*, 57 Nev. 131, 59 P. 2d 1165 (1936). There it was held that children could be emancipated for the purpose of owning cattle. We do not know how the Nevada courts would react to the concept of emancipation for the purposes of a minor's consenting to his own contraceptive services since the question has apparently not arisen (see discussion of this concept in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors).

Nevada has a statute which provides that in cases of emergency where "after reasonable efforts made under the circumstances," the parents of a minor cannot be located, consent for medical and surgical care for the minor may be given by any person standing in loco parentis to the minor. Nev. Rev. Stat. § 129.040 (1969).

"A local or state health officer, board of health, licensed physician or clinic" is authorized to examine and treat minors for venereal disease without parental consent. Nev. Rev. Stat. § 441.175 (as amended by Assembly Bill No. 70, 1971).

Under Nevada law parental rights may be terminated by court order for several reasons, including a court finding that a child is "neglected". Nev. Rev. Stat. §128.010 et seq., especially § 128.110 1969). For this purpose a "neglected child" is defined to be any child whose parent, guardian or custodian neglects or refuses, among other things, "to provide proper or necessary . . . medical or surgical care, or other care necessary for his health, morals or well-being." § 128.010 (3) (b).

We have found no cases indicating whether Nevada courts would accept the "mature minor doctrine" discussed in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

The state welfare department is authorized to provide family planning information and establish a policy of referral of welfare recipients for birth control; the health department is authorized to provide medical services, appliances, drugs and information for birth control. (See Laws Establishing Family Planning Programs, above). In the implementation of these statutes, the state health department requires parental consent for minors who have never married or given birth; the welfare department reports that although parental consent is not *required* for provision of services to minors, physicians or clinics may require parental consent for unmarried minors (See Welfare and Health Policy, Eligibility, below.)

Footnotes:

1. This does not seem to be limited to welfare recipients.
2. Nev. Rev. Stat. § 202.190. Prior to the repeal of Section 202.190, the Attorney General had expressed the opinion that Section 202.220, relating to the circulation of publications containing prohibited matter, forbade the installation and exhibition of vending machines containing contraceptives. Op. Atty. Gen. 1951, #35. Since contraceptives are no longer "prohibited matter", and since the 1967 revision of section 202.220 omitted all reference to section 202.190, it would appear that the prohibition against vending machines is no longer effective.
3. Ibid.
4. Want of age, and lack of parental consent are grounds for annulment; however a marriage remains valid unless and until declared void for such reasons by a court of competent authority. §§ 125.310, 125.320.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

In 1971, Nevada enacted a law to make "comprehensive voluntary family planning services readily

available to all persons desiring such services" (See Laws Establishing Family Planning Programs, above.) It is not clear whether "comprehensive voluntary family planning services" include voluntary sterilization.

Earlier Nevada statutes direct the health agency, within the limit of funds available, to "provide medical services, appliances, drugs and information for birth control" and authorize the welfare division to "conduct a family planning service in any county of the state" which "may include the dispensing of information and the distribution of literature on birth control and family planning methods." (See Laws Establishing Family Planning Programs, above.) Again, it is not clear whether voluntary sterilization is included.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current written policy on family planning of the Nevada Division of Health consists of a policy statement entitled "Birth Control Program" (State Division of Health Policies, Amendment of Chapter 11, Maternal and Child Health, dated May 1965). The policy is a reflection of the state legislature's amendment of state welfare and health laws in 1965 (Nev. Rev. Stat. § 422.235 and § 442.080), (See Laws on Contraception above). The law authorizes the welfare division to provide family planning informational services and to establish a referral policy for welfare recipients. Furthermore, "the health division shall, within the limits of funds available, provide medical services, appliances, drugs and information for birth control" (NRS 442.080, Section II, Page 2, Lines 10-11).

The policy itself reflects preliminary agreements among state, district, city and county health department officers on the conduct of family planning clinical services. The policy sets forth the following objectives of the family planning program: "(1) To serve as a clearinghouse, information, education and referral center for family planning. (2) To provide family planning services to those families unable to utilize other resources, consistent with the beliefs and morals of these persons. (3) To relieve public funds of the burden of supporting children unwanted by families, now dependent on public assistance, by making birth control consultation and services available to them." The policy goes on to establish eligibility standards, referral standards, the role of public health nursing, the scope of clinic sessions, clinic procedures, and administrative procedures.

2. *Eligibility:* A letter from the Chief of the Bureau of Maternal, Child and School Health and Crippled Children Services to the Region IX Program Management Officer, National Center for Family Plan-

ning Services, DHEW, dated December 1970, clarifies eligibility and patient fee policies. According to the 1965 policy statement cited above, the Nevada Division of Health recommends that family planning services be provided to medically indigent persons and to those who demonstrate "a need and who insist that they cannot obtain the services elsewhere." Priority is accorded to welfare recipients. According to the December 1970 letter, all categories of adults are eligible for family planning services; married minors and minors who "have had a baby" are eligible for services without parental consent. All other minors require parental consent. Geographical eligibility requirements and patient fees are locally determined.

3. *Administration:*¹ The Bureau of Maternal, Child and School Health and Crippled Children's Services has administrative responsibility for family planning services in the Nevada Division of Health. The Chief of the Public Health Nursing Section carries out all family planning administrative activities at the state level. Seventeen state supported health nurses assigned to local offices work less than 10 percent on family planning; 50-60 percent of the salaries for these public health nurses is paid by the state agency; about 40 percent is paid from local funds. The Division performs the following functions in support of family planning activities: Patient education and referral; general health education; consultation; development and distribution of public educational materials; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*² \$11,127 of new MCH funds were allocated to the Nevada Division of Health in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$191,580. An estimated \$56,500 of these funds were spent for family planning services. The Division received no specific appropriation for family planning from the state legislature in FY 1971. An estimated \$4,627 of additional state funds were spent for family planning services by the Division in FY 1971.

5. *Voluntary Sterilization:* The Nevada Division of Health has no written policy in regard to voluntary sterilization.

state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy is contained in the undated *Manual* of the Nevada State Welfare Division on pages 2, 6, 20, and 21. An additional policy statement is found in section 2-06-063 of the *Manual of the Department of Health, Welfare, and Rehabilitation*, dated December 1967. Older family planning policy is found in *Memorandum No. 42* to the welfare staff on July 9, 1965. Page 20 of the *Welfare Division Manual* states: "Each person for whom family planning services are appropriate, and who is eligible for services, will be offered information and assistance with respect to such services. The service worker will initiate and conduct discussions with respect to family planning." According to Section 2-06-063, "Cost of transportation cannot be authorized from assistance funds." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Welfare Division *requires* local agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, and private physicians. Voluntary agencies are not authorized to receive reimbursement under the current policy. The Division reports that there is a single, standard, statewide reimbursement rate for medical family planning procedures.² The reimbursement rates are as follows: Initial medical examination, \$7.00 for Calif. Relative Value Scale Unit, Annual medical examination, \$7.00 for Calif. Relative Value Scale Unit; IUD insertion, \$7.00 for Calif. Relative value Scale Unit; One cycle of oral contraceptives, Wholesale + \$2.30; Diaphragm, Retail. The Division also reported that it has contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. The Welfare Division does not fund or administer General Assistance Programs.

There are no additional limitations that affect the provision of services to adults. Parental consent is not *required* for the provision of services to minors. The Division, however, reported that physicians and

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the

health department clinics may require parental consent for all minors except those that are married.

4. *Administration:*⁴ Responsibility for administration for the family planning programs rests with the Family and Children's Services Unit in the State Welfare Division. The Chief of the Unit and two specialists spend less than 10 percent of their time on family planning activities. Family planning activities of the Unit include the training of district welfare staff, the development and distribution of educational materials, and the monitoring of policy implementation at district level.

5. *Financing:*⁵ The Department of Health, Welfare, and Rehabilitation received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Nevada State Wel-

fare Division has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Nevada Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices, when services are under supervision of a physician . . . Prior authorization of State office required for physician's visits in excess of three per month, for drug prescriptions, supplies, and devices exceeding cost of \$15. Reimbursement variable according to provider utilized." (The extent of utilization of the Medicaid program for family planning services is unknown. For additional information on Medicaid see the Federal Laws and Policies Section of this report).
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

New Hampshire

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in New Hampshire.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21.

The New Hampshire legislature has in effect endorsed the "mature minor doctrine" that a minor who is old enough and intelligent enough to understand the nature and consequences of proposed medical treatment can effectively consent to it without the necessity of parental consent. (See discussion in "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.") A recently enacted statute enabling any minor 12 years of age or older to submit himself to treatment for drug dependency without parental consent contains the following language:

Nothing contained herein shall be construed to mean that any minor of sound mind is legally incapable of consenting to medical treatment provided that such minor is of sufficient maturity to understand the nature of such treatment and the consequences thereof. N.H. Rev. Stat. Ann. § 318-B:12-a (Supp. 1971).

New Hampshire also has a law permitting any minor aged 14 or older to "voluntarily submit himself to medical diagnosis and treatment for a venereal disease." The statute provides that a licensed physician may diagnose, treat or prescribe for the treatment of a venereal disease in a minor 14 years of age or older without the knowledge or consent of the parent or legal guardian of the minor. N.H. Rev. Stat. Ann. § 141:11-a (added by Laws of 1972, Chapter 11, effective May 5, 1972).

On the basis of the New Hampshire judicial decisions on the subject of the emancipated minor (discussed below), it would seem that New Hampshire courts would probably follow the general common-law rule that an emancipated minor can effectively consent to his or her own medical care.

In *Aldrich v. Bennett*, 63 N.H. 415 (1885), it was

held that the marriage of a female minor who had attained what was then the statutory age of consent to marriage¹ emancipated her and terminated her father's legal claim to her services, even though the marriage was entered into against the father's wishes. The court held that "[t]he new relations created by the marriage, being inconsistent with the enforcement of parental rights, operate as an emancipation from them."

In *Jenness v. Emerson*, 15 N.H. 486 (1844), a 15-year-old boy whose father was dead and whose mother was insane and a pauper was held emancipated so that he could sue for his own earnings. The court said:

The plaintiff in this case was clearly in no sense under the control of his mother at the time of his employment with the defendant. He may well be considered as emancipated at that time from the control of his parents by misfortune, which may be as effectual for that purpose as the voluntary emancipation of them by their parents.

In *Clay v. Shirley*, 65 N.H. 644, 23 Atl. 521 (1874), a boy whose father had abandoned him and whose mother was poor and unable to support him was held emancipated so that he could sue for his own earnings. The court stated:

Emancipation is not to be presumed. It is a question of fact. Emancipation may be implied from circumstances, and may be inferred from the conduct of the parties interested.

New Hampshire has a statute which prescribes the manner in which a poor person can gain a legal settlement in any town so as to oblige the town to support that person. Until 1967, that statute provided that an emancipated minor would not take an after-acquired settlement from the parents, but could acquire one in his own right. The old law provided that, for purposes of poor-relief settlement, a minor could be emancipated "by the death or permanent insanity, or confinement in the state prison . . . of both parents, or of the father only and the subsequent marriage of the mother; by the marriage of the minor; by his having his time given him; and whenever the right of his custody, control, and services shall, by indenture or other instrument under seal, be transferred to a third person until twenty-one or for a term of years, unless such right

shall be again actually resumed by the parent and the minor shall become a part of his family." N.H. Rev. Stat. Ann. § 164:1 (repealed 1967).

The above-quoted statutory provision regarding emancipated minors was repealed in 1967 and replaced by the following provision with regard to an "employed minor":

VI. Employed Minor. A minor living apart from his parents, supporting himself and receiving the wages from his employment, may gain a settlement as if he were twenty-one years of age, except that if he resumes living with either of his parents, his settlement is the same as it was before his departure. This provision does not apply to a minor who is dependent in whole or in part upon his parent or guardian for support, or who is attending an educational institution. N.H. Rev. Stat. Ann. § 164-A:1 (1970 Supp.; effective Jan. 1, 1968).

We have found no cases indicating whether New Hampshire courts follow the general pattern of permitting medical treatment of minors without parental consent in emergencies.

A New Hampshire statute provides that the court may order a parent or guardian of a child alleged to be neglected or delinquent to provide necessary physical treatment. If the order is not obeyed within a reasonable time, the court is mandated to order treatment to be provided at the expense of the town where the child resides, and expenses shall be recovered from the person(s) chargeable by law for the child's necessities. N.H. Rev. Stat. Ann. § 169:17-a (1964).

The health department Program Policy and Procedure Manual indicates that all minors are eligible for family planning services without parental consent, while the welfare department requires parental consent for unmarried minors younger than 18. (See "Health and Welfare Policy," "Eligibility," below.)

Footnote:

1. The present age of consent for marriage is 20 years for males and 18 years for females. A marriage contracted by a person below the age of consent can be annulled in the discretion of the superior court at the suit of the party who at the time of contracting the marriage was below the age of consent, or at the suit of his or her parent or guardian, unless such party after arriving at the age of consent confirms the marriage. N.H. Rev. Stat. Ann. § 457:5 (1968). See *Sirois v. Sirois*, 94 N.H. 215, 50 A. 2d 88 (1946). A judge can, however, permit parties under age to marry with parental or guardian consent. § 457:6-7. Marriages contracted by a male younger than 14 or a female younger than 13 are declared null and void. § 457:4.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

New Hampshire has a statute which provides for the compulsory sterilization of inmates of state and

county institutions who are afflicted with certain incurable conditions. This statute contains the following provision:

Nothing herein shall be construed so as to prevent medical or surgical treatment for sound therapeutic reasons of any person in this state, whether such treatment involves the nullification or destruction of the reproductive functions or otherwise. N.H. Rev. Stat. Ann. § 174:12 (1964).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed on a person who is otherwise subject to the provisions of the compulsory sterilization law, the procedures prescribed in that law need not be followed although the operation may result in sterilization of the patient.

The Family Planning Manual used by the state health agency states that some public funds are available for voluntary sterilization services (See Health Policy, Sterilization, below).

The *Manual of the Division of Welfare* provides that family planning services shall include surgery for voluntary contraceptive sterilization. The CFPPD survey indicates that the Division of Welfare authorizes referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current policy on family planning of the Division of Public Health Services, New Hampshire Department of Health and Welfare, consists of a family planning *Program Policy and Procedure Manual*, issued by the Bureau of Maternal and Child Health, dated May 1970. The manual contains a general statement of goals which include promoting maternal and child health, increasing individual opportunity to determine family size and spacing, and reducing the incidence of unwanted pregnancy. Immediate objectives are to: "(1) Promote acceptance of family planning in New Hampshire as an individual's right to choose the size and spacing of families. (2) Extend public and private family planning resources where they exist and stimulate the development of new resources where needed. (3) Provide family planning medical services to those who cannot afford private services, [to those] who are not initially motivated to seek such services, and to persons who for reasons beyond their control cannot otherwise obtain comparable services. (4) Provide education and information to all interested citizens."

The policy summarizes the responsibilities of the MCH unit's family planning core staff. General requirements are set forth concerning eligibility, referral, patient charges, clinic waiting periods, availabil-

ity of contraceptive methods, and voluntarism. Local family planning programs are advised to develop patient advisory committees. Matching requirements for state-funded family planning programs are discussed. Standards are discussed for local family planning program operations including patient identification and contact, record keeping, referral, patient relations in clinics, transportation, requirements for physical exams, patient follow-up, requirements for confidentiality, and ancillary services. The policy briefly discusses voluntary sterilization.

2. *Eligibility*: The manual cited above states that "services shall be available":

Only to persons who are of *low income* or who for other reasons beyond their control cannot obtain services comparable to those provided in program centers. Specific income standards are applied flexibly with final determination of eligibility resting with the program director or her designate.¹

Without regard to age, race, religion, nationality, parenthood, maternity, or marital status.

Without any requirement for legal *residence* except that the person or family is currently living in the area served by the center.

Upon referral from any source including the patient's own application.

Without charge to any person receiving services or supplies under the program....

With respect to minors, the manual indicates that all minors are eligible for services without parental consent; however, the state health agency indicated in the CFPPD survey that eligibility for minors also "depends upon each individual physician."

3. *Administration*:² The Bureau of Maternal and Child Health has administrative responsibility for family planning services in the Division of Public Health Services. Staff assigned to family planning activities include: one coordinator, full-time; one manager, full-time; one director, 25–50 percent time; one education staff person, full-time; one training staff person, full-time; one nurse, 25–50 percent time; and one social worker, 25–50 percent time.

The Bureau performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and development of new clinics and special services, including youth services, vasectomy clinics, and "private referral services."

4. *Financing*:³ \$14,417 of new MCH funds were allocated to the state for FY 1971 which were federally earmarked for family planning services. All of these funds were obligated. The total allocation to the state of nonearmarked MCH funds for FY 1971 was

\$215,464. An estimated \$583 of these funds were spent for family planning services. The Division of Public Health Services received a \$10,000 appropriation for family planning services from the state legislature for FY 1972. No other state funds were spent by the Division for family planning.

5. *Voluntary Sterilization*: The Division of Public Health Services reported in the CFPPD survey that voluntary sterilization services for men and women are available in local private clinics and that the following "operating guidelines" apply: Income restrictions on eligibility for voluntary sterilization services are the "same as for any family planning patient; other restrictions depend on each individual physician and hospital." "Anyone contemplating a sterilization (male or female) must be carefully counseled by appropriate clinic staff including a physician. Application must be made to the program office for authorization prior to the performance of surgery, and the authorization must include a letter of explanation by the doctor performing the surgery," according to the *Program Manual* cited above. A small amount of public funds is available for voluntary sterilization services, according to the manual.

Footnotes:

1. The state health agency utilizes a financial eligibility ceiling of \$5,000 for a family of four which is similar to Federal standards for Crippled Children's Programs.
2. Information contained in this section was reported by the state health agency in the CFPPD survey.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in New Hampshire is contained in Sections 9950 through 9965 of the *Manual of the Division of Welfare* in the State Department of Health and Welfare, dated August 1969. According to section 9957 of the policy, "Family planning services include all services directed toward assisting a client to space his/her children or to limit the number of children he/she will have as follows: physician or clinic services, contraceptive drugs, contraceptive devices, nonprescription contraceptives (cream, jelly, foam, condoms), infertility diagnosis and treatment, surgery for voluntary contraceptive sterilization, and related social services." When the policy was issued in 1969, the above list included surgery for therapeutic abortion but this is no longer permitted. Section 9955 states that "The objectives of the Division's policy are to improve the health

of the people, to strengthen the integrity of the family, and to provide recipients the freedom of choice to determine the number and spacing of their children."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Division of Welfare *authorizes* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. Local agencies are *authorized* but not required to *purchase* family planning services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, voluntary agencies, and private physicians. The policy does not authorize the reimbursement of health departments. According to Section 9960, "Payment is made to a clinic providing such services [family planning] if the clinic regularly charges all patients a fee for services or supplies. Payment for family planning services or supplies is *not made to a public clinic providing free services or supplies to all patients.*" There is no single, standard, statewide reimbursement rate for medical family planning procedures.² The Welfare Division has no contracts or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. The Division of Welfare does not fund or administer a General Assistance Program.

There are no additional limitations that affect the provision of services to adults. Section 9950 states that "pending further policy development, these services [family planning] shall not be provided to unmarried minors under the age of 18." The Divi-

sion, however, reported that services may be provided to minors under 18 who have parental consent.

4. *Administration:*⁴ The Bureau of Medical Services and the Bureau of Social and Rehabilitation Services in the Division of Welfare share the administrative responsibility for the family planning program. The Assistant Director of Medical Services, the Chief of Social Welfare and the Assistant Director of Social and Rehabilitation Services spend less than 10 percent of their time on family planning activities. The training of local welfare staff is the main family planning activity of the bureaus.

5. *Financing:*⁵ The Department of Health and Welfare received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Division of Welfare has a written policy on voluntary sterilization which is contained in Section 9957 of the policy as quoted above. The CFPPD survey indicated that the Division *authorizes referral* for and the *purchase* of sterilization procedures by those local welfare agencies for eligible welfare recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the New Hampshire Medicaid program, family planning services are "Provided. Including drugs, supplies and devices. . . . Prior authorization required for nonlegend drugs, supplies, and devices. Basis of reimbursement variable, according to provider utilized." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

New Jersey

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in New Jersey.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* New Jersey has a statute which prohibits any person, "without just cause," from displaying, selling, advertising, or giving information about medicines, instruments or other things designed for the prevention of conception. N.J. Rev. Stat. § 2A: 170-76 (Supp. 1953). There have been numerous cases arising under this statute. Many of them focused on the phrase, "without just cause," and challenged it as unconstitutionally vague.

In *State v. Tracy*, 29 N.J. Super, 145, 102 A. 2d 52 (App. Div. 1953) *cert. denied*, 15 N.J. 79 (1954), the defendant was convicted under § 2A: 170-76 of selling condoms through vending machines in a gas station; the condoms were labelled "sold for the prevention of disease only." The court held that one must look to the "substantial designs" of an article; where one of these designs is the prevention of conception, any person who "without just cause" comes in possession of such an article with intent to sell it, is within the prohibition of § 2A: 170-76 even though the article was designed for the prevention of disease as well as for the prevention of conception. The words "designed for the prevention of conception," as used in the statute, apply to the intention of the designer or maker and not to the intention of the seller.

In *State v. Kohn*, 42 N.J. Super. 578, 127 A. 2d 451 (Essex Co. Ct. 1956) the court upheld the constitutionality of the statute, holding that the phrase "without just cause" was not unconstitutionally vague.

In *State v. Kinney Building Drug Stores, Inc.*, 56 N.J. Super. 37, 151 A. 2d 430 (Essex Co. Ct. 1959), three years later the Essex County Court held that the statute was unconstitutional because of the vagueness of the phrase "without just cause." The State of New Jersey did not appeal this ruling of the county court to the New Jersey Supreme Court.

The New Jersey Supreme Court later ruled on this statute for the first time in *Sanitary Vendors, Inc. v. Byrne*, 40 N.J. 157, 190 A. 2d 876 (1963).

The court held that the words "without just cause" do not apply to proper medical care and the like, and that the statute, so construed, is not unconstitutionally vague. Also in the view of the court, the phrase discloses legislative intent merely to regulate rather than prohibit the sale of contraceptives. Thus, the dispensation of contraceptives by physicians and druggists in the regular course of business is allowable under the statute, but indiscriminate sale of contraceptives through vending machines in public places is not permissible.

The latest ruling on the statute by the New Jersey Supreme Court (or indeed in any reported decision in New Jersey) was in *State v. Baird*, 50 N.J. 376, 235 A. 2d 673 (1967), where the court held that Section 2A: 170-76 does not prohibit the use of contraceptives, nor outlaw their display or exposure; it merely provides that their display or exposure is unlawful if "without just cause." Promiscuous and indiscriminate display or exposure of contraceptives at the street corner or in a children's playground would be "without just cause"; however, the display or exposure of contraceptives to a woman in a van parked in a municipal parking lot, incidental to a good faith explanation of birth control to the woman who had made specific inquiry on the subject, was with just cause.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* See above for discussion of § 2A: 170-76 and cases arising thereunder, especially *State v. Baird*.

3a. *Additional Laws Touching on Contraceptive Services:* New Jersey also has a statute concerning private nursing homes or hospitals which states that the licensing authority under this particular statute is not authorized to require such hospitals to permit or practice birth control, sterilization and other practices contrary to the dogmatic or moral beliefs of any well established body or denomination. N.J. Rev. Stat. § 30.11-9 (1964).

4. *Laws Relating to Contraceptive Services to Minors:* Effective January 1, 1973 the age of majority has been lowered to 18 for most purposes, specifically including the right to consent to medical and surgical treatment. Senate No. 992 (Official Copy Reprint), Ch. 81 (1972 Laws). Married or pregnant

minors are deemed to have the same legal capacity to act as a person of full age for the purposes of consenting to medical or surgical care. N.J. Stat. Ann. § 9:17A-1 (1971 Cum. Supp.). This statute also specifically affirms the right of pregnant minors to consent to medical or surgical care related to their pregnancy.

A minor who is or professes to be afflicted with a venereal disease may consent to medical and surgical care. N.J. Stat. Ann. § 9:17A-4 (1971 Cum. Supp.). The physician may but need not inform the spouse, parent, custodian or guardian as to the treatment given or needed without the consent, and even over the express refusal of the minor patient. N.J. Stat. Ann. § 9:17A-5 (1971 Cum. Supp.).

In the preamble to this act, which was passed in 1968, the legislature stated its reasons for enacting this legislation:

... Since contraction of a venereal disease is subject to serious reproach within the family circle, the necessary parental consent to treatment may not be sought by the minor because of fear or embarrassment. Allowing the child to secure competent medical treatment and to consent thereto, without the necessity for either knowledge by or consent of the parent, would eliminate one of the major bars to his seeking and receiving treatment. The threat to public health from venereal disease is of such gravity that the infected person should be treated as soon as diagnosed to protect his health and prevent the spread of the disease to others. In view of the danger posed and the increasing numbers of minors infected, it is essential that this highly vulnerable segment of our population be accorded greater freedom in securing prompt medical treatment.

The common law rule fixing the age at which a person may marry at 12 for females and 14 for males is in force in New Jersey. See *Fodor v. Kunie*, 92 N.J. Eq. 301, 112 Atl. 598 (1921). Before the age of majority was lowered to 18, males younger than 21 and females younger than 18 needed the consent of their parents or guardians in order to be issued a marriage license.¹ N.J. Stat. Ann. § 37:1-6 (1968). Presumably now only males younger than 18 need parental consent. New Jersey courts have held, nevertheless, that even if a marriage license is issued to a minor who does not have parental consent, such marriage is still valid. *Fodor v. Kunie*, *supra*; *Niland v. Niland*, 96 N.J. Eq. 438, 126 Atl. 530 (1924); *Ex Parte Olcott*, 141 N.J. Eq. 8, 55 A.2d 820 (1947). But see *In re State in Interest of I.*, 68 N.J. Super. 598, 173 A.2d 457 (1961).

Marriage emancipates a minor. *Rinaldi v. Rinaldi*, 94 N.J. Eq. 14, 118 Atl. 685 (1922); *Ex Parte Olcott*, *supra*. In the *Rinaldi* case, it was held that an infant emancipated by marriage remains emancipated even if she becomes a widow before reaching the age of majority.

Though we have found no cases involving medical treatment of emancipated minors, New Jersey courts do view emancipation as an extinguishment of parental rights and duties (see *Cafaro v. Cafaro*, 118 N.J.L. 123, 191 Atl. 472 (1937)) and thus, presumably, would follow the general pattern of permitting an emancipated minor to consent to his or her own medical care without the necessity of parental consent.

Under New Jersey law, there is a presumption against emancipation but this presumption may be overcome by establishing, for example, the requisite parental consent, either express or implied, to emancipation. *Cafaro v. Cafaro*, *supra*; *Straver v. Straver*, 26 N.J. Misc. 218, 59 A.2d 39 (1948). Emancipation is a question of fact and is not dependent per se on the age of the infant. *Estes v. Estes*, 15 N.J. Misc. 305, 191 Atl. 107 (1937). Some examples of how the New Jersey courts view emancipation follow:

In *Berla v. Meisel*, 52 Atl. 999 (N.J. Eq. 1902), the court held that a minor son who received his own wages, and lived at home paying his parents board and retaining the balance, was emancipated.

In *Estes v. Estes*, discussed above, a 19-year-old high school student who lived with his parents and assisted in his father's factory after school hours was held unemancipated, even though he received occasional five-dollar checks from his father for that assistance to pay for his clothes and other expenses. (This case was decided by the New Jersey Workmen's Compensation Board and involved the son's attempt to sue his father for compensation for injuries sustained in his father's factory.)

In *Cafaro v. Cafaro*, discussed above, a 19-year-old who had worked away from home and had given his wages to his mother in return for room, board, clothing and spending money, lost his job and proceeded to work in his father's grocery store on the same basis. He was held unemancipated because he was still subject to parental control and guidance. (This case involved the mother's attempt to sue her son for injuries she sustained when the car he was driving was involved in an accident). Despite the fact that the minor in the *Cafaro* case was held unemancipated, the case includes a lengthy discussion of the concept of emancipation and is often cited for the proposition that a minor may be partially emancipated, but that such partial emancipation should be given only the limited scope intended by the parents.

In *Williams v. Williams*, 91 N.J. Super. 273, 219 A.2d 895 (1966), cert. denied 222 A.2d 22 (1966), a 17-year-old replaced a former employee in his father's firm and earned \$63 a week, from which withholding taxes were deducted. However, he lived at home while paying no board and acquiesced in an arrangement by which his father retained parental control of his affairs. This youth was held partially

emancipated for the purposes of suing his father for workmen's compensation.

In *Greenspan v. Slate*, 12 N.J. 426, 97 A. 2d 390 (1953) the parents of a 17-year-old unemancipated minor were held liable for the cost of medical treatment furnished their child in an emergency, despite their claim that they hadn't authorized the treatment. There was no mention in the case of an action by the parents against the physician for assault for such allegedly unauthorized treatment of their child, but the case does illustrate the court's willingness to depart from general principles of law in emergency medical situations.

We have found no cases indicating whether New Jersey courts would accept the "mature minor doctrine" discussed in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

New Jersey has a statute providing "Neglect of a child shall consist in . . . wilfully failing to provide proper and sufficient . . . medical attendance or surgical treatment . . . or . . . failure to do or permit to be done any act necessary for the child's physical or moral well-being." N.J. Stat. Ann. § 9:6-1 (1960).

When the parents of a minor child "neglect to provide the child with proper protection, maintenance and education . . . any person interested in the welfare of such child [may] . . . institute an action . . . for the purpose of having the child brought before the court, and for the further relief provided by this chapter . . ." N.J. Stat. Ann. § 9:2-9 (1960). ("Child" is defined as any person under 21 in N.J. Stat. Ann. 9:2-13 (b) (1960). However, now that the age of majority is 18, presumably this definition will be changed so as to refer only to persons under 18.)

In several cases involving parents who were Jehovah's Witnesses who refused blood transfusions for their minor children, the courts have acted under the neglect statutes, discussed above, and ordered the appointment of a guardian and the award of custody of a child to the guardian for the limited purpose of providing the necessary medical attention, despite the objection of the parents. *State v. Perricone*, 37 N.J. 463, 181 A. 2d 751 (1962); *Hoerner v. Bertinato*, 67 N.J. Super 517, 171 A. 2d 140 (1961); *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A. 2d 537 (1964), cert. denied 377 U.S. 985. (See also *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A. 2d 670 (1971) where the court balanced the state's interest in preserving life via blood transfusions with an individual's religious beliefs.)

The question of balancing parents' religious beliefs, which were against contraception, with the state's interest in providing children with information on such matters was raised in *Valent v. New Jersey State Board of Education*, 114 N.J. Super. 63,

274 A. 2d 832 (1971). In that case the parents of minor school children brought an action against the Board of Education on the ground that requiring attendance of their children at a course entitled "Human Sexuality," which included discussion of such subjects as contraception, violated their constitutional rights. A motion by defendants for summary judgment was denied; the court said that a trial was necessary to balance the various interests involved.²

The Bureau of Children's Services may consent to medical care of any child under its care, custody or guardianship. N.J. Stat. Ann. § 30:4C-27 (1964).³

The Attorney General has stated that the State Board of Child Welfare does not have authority to consent to the performance of surgery on minor children in situations where the Board is not acting as legal guardian but is administering some form of welfare services to the children under N.J. Stat. Ann. 30:4C-5. Op. Atty. Gen. Feb. 20, 1953, No. 3.

New Jersey welfare department policy calls for provision of family planning services to "all individuals regardless of age, marital status or parental status," and includes no condition requiring parental consent for minors. (See Welfare Policy, Eligibility, below.)

Footnotes:

1. Males younger than 18 or females younger than 16 who wish to marry must have the required parental consent approved by a judge of the County Court or Juvenile and Domestic Relations Court. § 37:1-6.
2. We have been informed (by the Valent's attorney) that plaintiffs were directed to exhaust their administrative remedies before seeking a remedy in the courts.
3. New Jersey also has a law concerning medical treatment for legally disabled incompetents and minor inmates in state and county mental and correctional institutions. N.J. Stat. Ann. 30:4-7.1 to 30:4-7.6 (1972 Cum. Supp.) This law permits the chief executive officer of such institution to consent to medical care for such inmates younger than 21 where he knows of no parent or guardian competent to consent to the minor's medical care, or where the parent or guardian fails to respond to a request for consent, and where a physician "certifies that the treatment to be performed is essential and beneficial to the minor or will improve his opportunity for recovery or prolong or save his life." § 30-4-7.2. The chief executive officer may also consent to emergency treatment for minor inmates. § 30:4-7.3. He is exempt from personal liability when granting his consent under the above circumstances. § 30-4-7.2.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians, with one exception: A New Jersey statute provides that the licensing authority or agency cannot require any hospital to "practice or permit sterilization of human beings . . . or any other similar practice contrary to the dogmatic or moral beliefs of any well established reli-

gious body or denomination." N.J. Stat. Ann. § 30:11-9 (1964). By necessary implication this statute makes clear that voluntary sterilization is legal in New Jersey and that the applicable law is the same as for other surgical procedures.

In *West v. Underwood*, 132 N.J. L. 325, 40 A. 2d 610 (1945), it was held that a woman could recover damages for negligent failure to tie her fallopian tubes in the course of a caesarian delivery, as the defendant doctor had undertaken to do. The New Jersey Court of Errors and Appeals assumed that there was no question about the legality of voluntary sterilization.

The state health agency has a policy which includes voluntary sterilization as a family planning service for which referrals are made. (See Health Policy, Sterilization, below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The current written policy on family planning of the State Department of Health consists of a section of the Department's *Personnel and Program Standards for Certified Health Services* (revised October 1970), which authorizes family planning services as a certified health service for local health departments and *Standards for Family Planning Services*, dated January 1971. The latter describes: *personnel standards* for medical personnel, nursing personnel, social service personnel, and ancillary staff; *medical procedures* for new patients, revisits by continuing patients, oral contraceptives, IUDs, diaphragms, the rhythm method, and other contraceptive methods; *additional services*, including pregnancy testing and referral, nutrition services, infertility services, and voluntary sterilization; and *standards for family planning facilities*.

2. *Eligibility*:¹ Financial, social and geographical eligibility requirements, as well as patient fees or payments, are determined by local health agencies.

3. *Administration*: The Family Planning Program, Division of Community Health Services, has administrative responsibility for family planning services in the State Department of Health. Staff assigned to family planning responsibilities at the state level include the following full-time personnel: the Family Planning Program Coordinator, two nursing consultants, and one physician consultant. The Director of Parental and Child Health Services devotes 10-25 percent time to family planning, and the Coordinator of Maternal and Child Health programs devotes less than 10 percent time to family planning.

The Department performs the following functions in support of family planning services: consultation, training, development and distribution of public educational materials, central data process-

ing, statewide program development, and grants or contracts to local family planning programs.

4. *Financing*:² \$186,858 of new MCH funds were allocated to the State Department of Health in FY 1971 which were federally earmarked for family planning; \$180,961 or 96.8 percent of these funds were obligated for family planning services. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$874,629. An estimated \$119,039 of these funds were spent for family planning services. The Department received a \$100,000 appropriation for family planning from the state legislature in FY 1971. Additional state funds utilized by the Department for family planning include an undetermined amount of state aid to local health departments.

5. *Voluntary Sterilization*: The State Department of Health's *Standards for Family Planning Services* contain the following written policy on sterilization: "For couples who desire a sterilization procedure performed, appropriate referrals should be made."

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in New Jersey is contained in Circular Letter No. 538, dated October 1968 and in Circular Letter No. 583, dated January 1969 of the Division of Public Welfare in the Department of Institutions and Agencies. Circular Letter No. 583, which like Letter 538 went to county welfare directors, states that family planning "advice shall be given, regardless of receipt of a specific request therefor, if in the professional judgment of the caseworker or supervisor it is an appropriate element of the social service plan for ameliorating the family's problem." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Division of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. However, except for medical family planning services provided to General Assistance recipients, the Division of Public Welfare *does not* itself *purchase* family planning services for eligible public assistance recipients.² There is no single standard, statewide reimbursement rate for medical family planning procedures. The Division has no contracts and/or other formal arrangements with providers of services

for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as applicants, past recipients, and potential recipients of Aid to Families with Dependent Children assistance are eligible for medical family planning services. Former recipients and potential recipients of Aid to the Permanently and Totally Disabled and Aid to the Blind are eligible for referral only. There is no information as to whether residents of low-income areas are covered by the policy. General Assistance recipients are eligible for medical family planning services.

There are no additional limitations that affect the provision of services to adults or minors. Letter No. 583 states that family planning "services shall be offered to all individuals, regardless of age, marital status or parental status."

4. *Administration:*⁴ The Bureau of Social Services in the Division of Public Welfare is responsible for the administration of the welfare family planning program. No staff are assigned either full- or part-time to family planning. Activities of the Bureau are confined to the development and distribution of public educational materials.

5. *Financing:*⁵ The Department of Institutions and Agencies received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Division of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Division leaves the question of referral for sterilization procedures to the option of local welfare agencies.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the New Jersey Medicaid programs, family planning services are "Provided. No limitations. . . . Basis of reimbursement varies according to type of vendor." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

New Mexico

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: There is no law establishing a state family planning program in New Mexico.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: None found.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 18. N.M. Stat. Ann. § 13-13-1 (1971).

Emancipated and lawfully married minors may consent to medical and surgical care. N.M. Stat. Ann. § 12-12-1 (1967). Subsequent judgment of annulment or divorce does not deprive the minor of his adult status once such status is attained. *Ibid.*

In *Fitzgerald v. Valdez*, 77 N.M. 769, 427 P. 2d 655, 659 (1967), the court said that a child is emancipated "once the family relationship is altered so that the child is no longer subject to parental care and discipline. Emancipation as between parent and child is a severance of the parental relationship so far as legal rights and responsibilities are concerned."

According to N.M. Stat. Ann. § 57-1-5 (1967) males younger than 21 and females younger than 18 need the consent of their parents or guardians to marry. However, the age of majority was lowered to 18 in 1971; presumably the effect of this on Section 57-1-5 is to change the age of consent to 18 for both sexes. Section 57-1-6 provides: "No person authorized . . . to celebrate marriages shall knowingly unite . . . any male under the age of eighteen or female under the age of sixteen with or without the consent of their parents or guardians . . ." with certain exceptions such as pregnancy.

A minor, regardless of age, can consent to examination and treatment by a licensed physician for venereal disease. N.M. Stat. Ann. § 12-3-41 (1971).

A minor, regardless of age, can consent to examination and diagnosis by a licensed physician for pregnancy. N.M. Stat. Ann. § 12-3-42 (1971).

Any person standing in loco parentis can effectively consent for emergency medical attention or

surgery when the parents cannot be located after reasonable efforts. N.M. Stat. Ann. § 12-12-2 (1967). For this purpose "emergency" is defined as "an unexpected occurrence involving injury or illness to persons including motor vehicle accidents and collisions, disasters, and other accidents and events of similar nature occurring in public or private places." N.M. Stat. Ann. § 12-12-4 (1967).

We have no relevant information as to whether New Mexico courts would accept the "mature minor doctrine" discussed in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

The welfare department policy does not list any parental consent requirements for service to minors, but the department does not itself purchase contraceptive services for welfare clients. (See Welfare Policy, Eligibility, below.)

B. Laws Relating to Voluntary Sterilization

Two 1970 statutory provisions make clear that voluntary sterilization is legal in New Mexico.

The first of these provides that if a woman has been abandoned by her spouse, it is unnecessary for her spouse's consent to be obtained when performing "voluntary medical sterilization." This provision applies only to women "otherwise capable of consenting to medical treatment." N.M. Stat. Ann. § 12-3-43 (Supp. 1970).

The other new statutory provision prohibits a hospital and medical staff from setting up special qualifications for the performance of sterilization operations, "which are not imposed on individuals seeking other types of operations in the hospital." N.M. Stat. Ann. § 12-3-44 (Supp. 1970).

This is clearly an attempt to discourage hospitals, physicians and health agencies from imposing special requirements as prerequisites to voluntary sterilization such as an age-parity formula or the like.

Local health department offices may provide information on sterilization upon patient request. (See Health Policy, Sterilization, below.)

The CFPPD survey indicates that the State Social and Rehabilitation Services Division requires local welfare agencies to refer eligible welfare recipients who wish it for sterilization procedures. (See Welfare Policy, Sterilization, below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Medical Services Division, New Mexico Health and Social Services Department, has no formal written policy on family planning. However, in a letter to the Region VI Program Director, National Center for Family Planning Services, DHEW, dated November 13, 1970, the Chief of the Maternal and Child Health Section described current practices relating to financial and social eligibility requirements and patient fees for family planning services.

2. *Eligibility:* The Health and Social Services Department neither recommends nor establishes eligibility criteria or patient fees for local health agencies. However, according to the letter cited above, "In some areas where clinics are run by other agencies and [are] partially supported by [the] Health and Social Services Department, there are certain [local] requirements imposed. . . . Health Departments do furnish services for unmarried and nulliparous women. However, we are somewhat constrained, in theory at least, by state law which prohibits examination and treatment of minors for any purpose without the consent of their parents. . . . There is no cost to patients for clinic services. Because of our budget problems, patients must buy some supplies themselves."

3. *Administration:*¹ The Maternal and Child Health Section has administrative responsibility for family planning services in the Medical Services Division, Health and Social Services Department. Staff assigned to family planning activities include: one medical doctor, 25–50 percent time; one nursing consultant, 25–50 percent time; one program support specialist, 10–25 percent time; and one secretary, 10–25 percent time. The Department performs the following functions in support of family planning activities: consultation; training; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and partial payment of local staff salaries.

4. *Financing:*² \$43,483 of new MCH funds were allocated to the state for FY 1971 which were federally earmarked for family planning services; \$281,543 of nonearmarked MCH funds were allocated to the state. A total of \$68,000 of MCH funds from these allocations were spent for family planning services. The Health and Social Services Department received no appropriation from the state legislature specifically for family planning in FY 1971 and no other state funds were spent by the health agency for family planning.

5. *Voluntary Sterilization:* The Medical Services

Division has no written policy in regard to voluntary sterilization; however, local health offices may provide information on sterilization and abortion upon patient request, according to the CFPPD survey. No funds are available to purchase these services.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in New Mexico is confined to brief statements in Subsections K and Y in Section 303.2 of the *Medical Assistance Manual*, dated January 1, 1970, issued by the Health and Social Services Department. Subsection K authorizes payment for "devices for family planning" and three refills of "contraceptive tablets" within six months with a maximum of three refills. The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Social and Rehabilitation Services Division *requires* local welfare agencies to *refer*, "upon client request," eligible public assistance recipients to medical family planning services. The Division *does not* itself *purchase* medical family planning services, and it reported that "we are unable to use state funds (other than title XIX) for family planning for unwed mothers as we have in the past, due to severe limitations of these funds." It would appear that such service sources as hospital outpatient clinics and private physicians are expected to provide the necessary medical services.² There is no single, standard, statewide reimbursement rate for medical family planning procedures. The Division has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. The Division does not fund or administer a General Assistance program.

There are no additional limitations that affect the provision of services to adults or minors.

4. *Administration:*⁴ The Social and Rehabilitation Services Division and the Medical Assistance Division of the State Health and Social Services Depart-

ment share administrative responsibility for the welfare family planning program. No staff are assigned either full- or part-time to family planning. Family planning activities are limited to the development and distribution of public educational materials.

5. *Financing:*⁵ The Health and Social Services Department received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Health and Social Services Department has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *requires* local welfare agencies

to refer eligible public assistance recipients who wish them for sterilization procedures.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the New Mexico Medicaid program, family planning services are "Provided. No limitations. . . . Reimbursement on variable basis according to provider utilized." The extent of utilization of the Medicaid program for family planning is unknown. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

New York

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: In 1971, New York passed a law directing each Social Services Commissioner to require his staff to advise eligible needy persons periodically of the availability at public expense of "family planning services" and to inquire whether such persons wish to have "family planning services" furnished them. Under the law, no person is to be required or coerced to request or receive family planning services. Where desired, such services must be made available at public expense. N.Y. Soc. Services Law § 131-e (McKinney Supp. 1971).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: Section 6811 (8) of the New York Education law permits the sale or distribution of contraceptives to all persons 16 and over, but such sale or distribution is authorized only by a licensed pharmacist. N.Y. Educ. Law § 6811 (8) (McKinney Supp. 1971).¹

Section 6811 (8) reflects a liberalization of the law in New York regarding contraceptives effectuated by the 1965 repeal of former Section 1142 of the Penal Code. This repealed section prohibited the manufacture, sale, distribution and advertisement of "indecent articles," among which were included articles and medicines for the prevention of conception. Former Section 1145 of the Penal Code exempted from classification as "indecent articles," articles or instruments used or applied by physicians (or by their direction or prescription) in their lawful practice for the cure or prevention of disease.

Section 6807 (b),² N.Y. Educ. Law (McKinney Supp. 1971) (relating to exempt persons) exempts any physician who is not the owner or in the employ of an owner of a pharmacy or registered store from (among other restrictions³) the limitations on sale or distribution of contraceptives contained in §6811 (8). Thus, physicians may supply their patients with such drugs as they deem proper.

Section 6807 (c) of the Education Law⁴ permits any merchant to sell "proprietary medicines" which are not deleterious or proscribed by the public health law. Thus, medicines which are classified as "proprietary" can be sold at retail outlets other than licensed pharmacies. *Schwartz v. Bersani*, 50 Misc. 2d 1044, 272 N.Y.S. 2d 179 (1966).

In *Loblaw v. New York State Board of Pharmacy*, 11 N.Y. 2d 102, 226 N.Y. Supp. 2d 681, 181 N.E. 2d 621 (1962), the court held that Bayer aspirin, a trademarked product, was a "proprietary medicine." The criteria upon which the court based its opinion were that the aspirin was prepackaged and ready for consumer use, there was no opportunity for inspection or analysis by the pharmacist, Bayer was a brand name produced by a reliable manufacturer upon whom there was public reliance; and consequently, since there was no professional judgment or skill of the pharmacist involved, no additional health protection was afforded the public by restricting the sale of Bayer aspirin to pharmacies. While the criteria used in the *Loblaw* case could readily apply to nonprescription contraceptive articles such as condoms, foams, jellies, etc., as well as to Bayer aspirin, it is unclear whether § 6807 (c) would be interpreted as applicable to contraceptives.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: Section 6811 (8) makes it a misdemeanor to advertise or display contraceptives within or without the premises of a pharmacy. N.Y. Educ. Law (McKinney Supp. 1971).

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority in New York is 21 years. N.Y. Dom. Rel. Law § 2 (McKinney 1964). However, any person who is 18 years of age or older, or is the parent of a child or has married, may give effective consent for medical, health and hospital services. N.Y. Pub. Health Law § 2504 (signed by Governor Nelson Rockefeller, June 2, 1972). Medical, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when "in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health." *Ibid.* The same law provides that "[A]nyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent."

It is unclear under what circumstances parental consent may be required for general medical care

or minors younger than 18 years.⁵

Age of Consent to Contraceptive Services: Pharmacists may sell or distribute any instrument or article or any recipe, drug or medicine for the prevention of conception to a minor 16 years of age or older. N.Y. Educ. Law § 6811 (McKinney Supp. 1971). Most physicians are exempted from the limitations of the Pharmacy Law. N.Y. Educ. Law § 6807 (McKinney Supp. 1971) (See Laws on Sale and Distribution of Contraceptives, above.)

A recently enacted statute (see Laws Establishing Family Planning Programs, above), requires that eligible needy persons be advised periodically of the availability at public expense of family planning services for the prevention of pregnancy and be asked whether they desire such services. In cases where such services are desired, the statute provides that they shall be made available at public expense. The statute contains no restrictions as to age. N.Y. Soc. Services Law § 131-e (McKinney Supp. 1971). The New York Department of Social Services has issued a regulation under the new statute which provides: "Family planning services and information relating thereto shall be made available without regard to the recipient's marital status, age or parenthood." D.S.S. Reg. § 386.16. (See Welfare Policy, Eligibility, below.)

New York Public Health Law § 2305-2 (McKinney Supp. 1972) provides that a physician may diagnose, treat or prescribe for a person under 21 who has or has been exposed to a venereal disease without the consent or knowledge of the parent or guardian of said person.

Court Decisions Respecting Medical Treatment of Minors: Even before enactment of New York Public Health Law § 2504 giving physicians the right to treat minors in an emergency without parental consent, a New York court had held that a physician confronted with an emergency did not have to delay treatment by seeking parental consent. *Sullivan v. Montgomery*, 155 Misc. 448, 279 N.Y. Supp. 575 (City Ct. of N.Y. Bronx Co. 1935). In the *Sullivan* case, a 20-year-old boy injured his ankle during a baseball game and was taken to a physician for examination. The boy consented to be anesthetized and to have his ankle set. In a subsequent suit by the boy's father against the doctor for alleged malpractice and assault, the court denied recovery on the ground that emergency treatment was required even though no parental consent had been obtained. The court stated:

...if a physician or surgeon is confronted with an emergency which endangers the life or health of the patient or that suffering or pain may be alleviated, it is his duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same locality. Many persons are injured daily in our city and emergency cases constantly arise. To hold that a

physician or surgeon must wait until perhaps he may be able to secure the consent of the parents, who may not be available, before administering an anaesthetic or giving to the person injured the benefit of his skill and learning, to the end that pain and suffering may be alleviated, may result in the loss of many lives and pain and suffering which might otherwise be prevented. I do not believe that those who have devoted their lives to humanity will wantonly administer an anaesthetic or fail to obtain the consent of parents before administering an anaesthetic where such consent may reasonably be obtained in view of the exigency; it would be altogether too harsh a rule to say that under the circumstances disclosed by the testimony in the instant case, the defendant should be held liable because he did not obtain the consent of the father to the administration of the anaesthetic; as the defendant was confronted with an emergency, and as he obtained the consent of his patient, I hold that the consent of the father was not necessary. . . . 155 Misc. at 449-50.

Also before the enactment of New York Public Health Law § 2504 (giving all married persons the right to consent to their own medical care), a New York court held that a 19-and-a-half year-old married woman could validly consent to nonemergency medical treatment (biopsy for a skin disorder). *Bach v. Long Island Jewish Hospital*, 49 Misc. 2d 207, 267 N.Y.S. 2d 289 (Sup. Ct. Nassau Co. 1966). While this case also supports the "mature minor doctrine" (see discussion below), it clearly establishes that a minor can be emancipated for the purpose of consenting to his or her own medical care in New York.

A minor is ordinarily emancipated by marriage. *Cochran v. Cochran*, 196 N.Y. 86 (1909); *Kinsey v. Kinsey*, 200 Misc. 760, 765, 107 N.Y.S. 2d 212 (Dom. Rel. Ct. 1951); *In re Palumbo*, 172 Misc. 55, 14 N.Y.S. 2d 329 (Dom. Rel. Ct. 1939).⁶ A minor will generally be deemed emancipated if he or she lives apart from his or her parents, is self-supporting, and generally controls his or her own life. See *Cohen v. Delaware, L. & W. RR.*, 150 Misc. 450, 269 N.Y. Supp. 667 (Sup. Ct. N.Y. Co. 1934). A minor living apart from his or her parents with their consent may be emancipated even though they still support the minor. *Matter of Stillman v. School District*, 60 Misc. 2d 819, 304 N.Y.S. 2d 20 (Sup. Ct. Nassau Co. 1969), aff'd, 34 App. Div. 2d 553 (2d Dep't 1970). Some case law indicates that a minor who still lives in the parental home may be emancipated if he or she pays living expenses to the parents and uses the remainder of the earnings as he or she sees fit. (E.g., *Crosby v. Crosby*, 230 App. Div. 651, 246 N.Y. Supp. 384 (3d Dep't 1930); *Giovagnoli v. Fort Orange Construction Co.*, 148 App. Div. 489, 133 N.Y. Supp. 92 (3d Dep't 1911).) It is the intention of the parent which governs (*Matter of Bates v. Bates*, 62 Misc. 2d 498, 310 N.Y.S. 2d 26 (Fam. Ct. Westchester Co. 1970).) A minor can also be emancipated by failure of the parents to meet their legal responsibilities (see *Murphy v. Murphy*, 206 Misc. 228, 133 N.Y.S.

2d 796 (Sup. Ct. Madison Co. 1954)).

A minor is ordinarily emancipated while performing military service, relieving the father of support obligations. *Matter of Fauser v. Fauser*, 50 Misc. 2d 601, 271 N.Y.S. 2d 59 (Fam. Ct. Nassau Co. 1966); *Staten Island Hospital v. Porter*, 59 M. 2d 389, 298 N.Y.S. 2d 598 (Civil Court Richmond Co. 1969). (A contrary result has been reached where the father's support obligation stems from a separation agreement which does not provide for the contingency of military service. *Harwood v. Harwood*, 182 Misc. 130, 49 N.Y.S. 2d 727 (App. Term. 1st Dep't 1944), aff'd 268 App. Div. 974, 52 N.Y.S. 2d 573 (1st Dep't 1944), motion for leave to appeal denied 268 App. Div. 1038, N.Y.S. 2d 308 (1st Dep't 1945); *Craig v. Craig*, 24 App. Div. 2d 588, 262 N.Y.S. 2d 398 (2d Dep't 1965); *Eisenberg v. Eisenberg*, 59 N.Y.S. 2d 534 (Sup. Ct. Kings Co. 1945); *Wack v. Wack*, 74 N.Y.S. 2d 435 (Sup. Ct. Westchester Co. 1947).)

There is language in two New York cases, i.e., in *Bach v. Long Island Jewish Hospital* and *Sullivan v. Montgomery*, cited above, indicating that the age (19-and-one-half and 20, respectively) and intelligence of the minors involved in those cases were a major factor in the courts' decisions that parental consent was not required in either case. (See Lieberman, Caveat-Medical Treatment of Minors, 4 Ill. Cont. Legal Educ. 99 (Oct. 1966), viewing *Sullivan v. Montgomery* as upholding the right of a mature minor to consent to medical treatment).

In *Bach v. Long Island Jewish Hospital* (see above), the court recognized a distinction between the personal rights and the property rights of minors and went on to say:

While a minor may not alter the status of his property rights in this jurisdiction without the intervention of a guardian or a court as *parens patriae*, the minor's personal rights are not so closely stricured.

In this case there is nothing to suggest that the plaintiff at the time of executing the consent had not reached the age of discretion, or that plaintiff was under any physical or mental disability. Plaintiff's consent to the surgical procedure involved was an act of volition and was a personal right which was validly exercised. 49 Misc. 2d at 208-209.

It has been pointed out above that New York permits the sale and distribution by pharmacists of contraceptive drugs and devices to minors 16 and older (N.Y. Educ. Law § 6811 (McKinney Supp. 1971)) and that, as of 1972, 18-year-olds may consent for their own medical, health and hospital care. N.Y. Pub. Health Law § 2504. Under New York law, 17-year-olds may consent to sexual intercourse. (N.Y. Penal Law § 130.05 (3) (a) McKinney 1967); and 18-year-old girls may marry without parental consent.⁶ The New York City Health and Hospitals Corporation policy on abortion for minors in municipal hospitals is that no parental consent is required

where the patient is "married, emancipated or at least 17 years old," or if seeking parental consent would "endanger the physical and mental health of the patient."

New York also has a statute giving the family court power to order medical care for a neglected child without parental consent. N.Y. Judiciary Law (Family Court Act) § 232 (Supp. 1971). The predecessor of this statute was held constitutional in *In re Vasko*, 238 App. Div. 128, 263 N.Y. Supp. 552 (2d Dep't 1933), where the court directed removal of the cancerous eye of a two-year-old child over the parents' objections; see also *In re Rotkowitz*, 175 Misc. 948, 25 N.Y.S. 2d 624 (Children's Court 1941); *In re Carstairs*, 115 N.Y.S. 2d 314 (Dom. Rel. Ct. 1952). The court's power under § 232 is not limited to "drastic situations" or to those which constitute a "present emergency"; rather, the court has wide discretion to order medical or surgical care and treatment for an infant even over parental objection, if in the court's judgment the health, safety or welfare of the child requires it. *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S. 2d 641 (Fam. Ct. 1970), aff'd, 37 App. Div. 2d 668, 323 N.Y.S. 2d 253 (3rd Dep't 1971).

A recent New York statute authorizes the Commissioner of Social Services or the Commissioner of Health to give effective consent for medical, dental, health and hospital services for any abused child under the age of 16. N.Y. Soc. Services Law § 383-b (added by S. 8443, Ch. 592, effective September 1, 1972).

Footnotes:

1. Before a 1971 amendment, the provisions of § 6811 (8) were found in § 6804-b.
2. Before a 1971 amendment, the provisions of § 6807 (b) were found in § 6816-1.
3. § 6807 (b) is a general exemption for physicians, dentists and veterinarians from the limitations of Article 137 (Pharmacy) of which § 6807 is a part.
4. Before a 1971 amendment, the provisions of § 6807 (c) were found in § 6816-2-c.
5. While the contours of the rule in New York State were never entirely clear, it has been assumed that parental consent is required. See *Fiorentino v. Wenger*, 26 App. Div. 2d 693, 272 N.Y.S. 2d 557 (2d Dep't 1966), reversed as to defendant hospital only, 19 N.Y. 2d 407 (1967); *Anonymous v. State of New York*, 17 App. Div. 2d 495, 497, 236 N.Y.S. 2d 88, 90 (3rd Dep't 1963).
6. By statute in New York, "any marriage in which the man is under the age of sixteen years or in which the woman is under the age of fourteen years" is prohibited. N.Y. Domestic Rel. Law § 15-a (McKinney 1964). A marriage is voidable, i.e. void from the time its nullity is declared by a court of competent jurisdiction, if either party "is under the age of legal consent, which is eighteen years, provided that such nonage shall not of itself constitute an absolute right to the annulment of such marriage, but such annulment shall be in the discretion of the court which shall take into consideration all the facts and circumstances surrounding such marriage." N.Y. Domestic Rel. Law § 7 (McKinney 1964). When

application is made to the city or town clerk for a marriage license, if it appears that the man is younger than 21 but not younger than 16, or that the woman is younger than 18 but not younger than 14, then the city or town clerk before issuing a license must obtain the written consent of the parents or guardians of such minor or minors. N.Y. Domestic Rel. Law § 15 (McKinney Cum. Supp. 1971). The marriage of a girl younger than 16 following which she and her husband lived together for nine years has been held valid whether or not parental consent was obtained. *Matturro v. Matturro*, 281 App. Div. 695, 117 N.Y.S. 2d 523 (2d Dep't 1952); see N.Y. Domestic Rel. Law § 25 (McKinney 1964).

The New York Court of Appeals has held that a marriage between two 18-year-olds entered into against the wishes of the young man's parents had the effect of emancipating him and giving his wife rather than his father the right to his wages. *Cochran v. Cochran*, 196 N.Y. 86 (1909). Where, however, a 16-year-old married without his parents' consent, it was held that the marriage did not emancipate him, at least pending an action brought by the father to annul the marriage, since he was under the statutory age of consent of 18. *Wolf v. Wolf*, 194 App. Div. 33, 185 N.Y. Supp. 37 (2d Dep't 1920).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Two recent suits to force hospitals to perform sterilization make clear that voluntary sterilization is legal in New York.¹

McCabe v. Nassau County Medical Center, Docket No. 71-1371 (U.S. Ct. Ap. 2d Cir. 1971), was an action against a public hospital and its officials who refused to sterilize Mrs. McCabe. She sought an order compelling the hospital to perform the surgery and also claimed damages. The hospital's refusal was based on an age-parity formula under which Mrs. McCabe had to have five children before she could be sterilized. (She was actually 25 years old and had four small children.) Because of inability to pay, Mrs. McCabe alleged that she could not go to a private hospital and find a doctor who would perform the operation. After the suit was commenced, the hospital reversed its position and performed the sterilization. The trial court thereupon dismissed the action as "moot and academic."

The United States Court of Appeals for the Second Circuit (New York and Connecticut) reversed the lower court's dismissal of the action and held that performance of the surgery did not extinguish Mrs. McCabe's claim for damages. The court did not rule on the merits of plaintiff's claim, which was based on alleged violation of her constitutional rights, but sent the case back to the district court for a full adjudication.

Plaintiff's claim was that because the hospital is a public institution, its refusal to sterilize her, based

on the hospital's regulations, was taken under color of state law in violation of her rights under the First, Fifth, Eighth, Ninth and Fourteenth Amendments to the Constitution of the United States. She argued that through use of an arbitrary age-parity formula, defendants violated her constitutional rights by attempting to decide how many children she and her husband should have and by what means they may prevent conception. The court held that she had stated a cause of action for damages.

Judge Moore, who dissented on the ground that in his opinion the hospital's action was not taken under color of state law, pointed out in his dissenting opinion that "New York allows sterilization. That certain doctors may in a specific case perform, or in specific situations are unwilling to perform, a sterilization operation is not due to the compulsion of any State statute or regulation."

A similar suit was brought by a woman against the Peekskill Community Hospital and its administrator to compel them to permit surgical sterilization. *Caffarelli v. Peekskill Community Hospital*, Docket No. 71-3617 (D. Ct. S.D. N.Y. 1971). The court ruled that it would order defendants to permit performance of the sterilization procedure if they failed to do so voluntarily within the time fixed by the court. The plaintiff had agreed to withdraw her suit and her claim for damages if the defendants in fact permitted the sterilization procedure to be performed. The surgical procedure was performed upon Mrs. Caffarelli at defendant hospital and the suit was discontinued.

A 1967 New York Attorney General's opinion recognizes the legality of voluntary sterilization for contraceptive purposes in New York. However, the Attorney General stated that state Medicaid payments should not be made for voluntary sterilization procedures for purely contraceptive purposes in the absence of legislation specifically authorizing such payments. The opinion states that such payments are authorized where "sterilization results as an incident to the implementation of recognized surgical procedures and medical care employed to cure or correct a medical disease or disorder." *Letter from Attorney General Louis J. Lefkowitz to Commissioner of Social Services George K. Wyman, and Commissioner of Health Hollis S. Ingraham*, August 21, 1967.

The State Department of Health policy (as amended following this opinion) states that surgical sterilization procedures may be paid for from medical assistance funds where there is medical (including psychiatric) necessity for such care. *State Medical Handbook—Policies and Standards for Physician Services—Policy on Surgical Sterilization*.

However, under a statute enacted in 1971 (See Laws Establishing Family Planning Programs,

above), eligible needy persons must be advised of the availability at public expense of "family planning services for the prevention of pregnancy" and such services must be made available at public expense where desired. It is not stated whether "family planning services for the prevention of pregnancy" include voluntary sterilization.

Footnote:

1. An old New York film censorship case, *Foy Productions v. Graves*, 253 App. Div. 475, 3 N.Y.S. 2d 573 (3d Dep't 1938), aff'd, 278 N.Y. 498 (1938), upheld the denial of a license for a motion picture dealing with compulsory sterilization. The opinion of the intermediate appellate court contains some language describing sterilization for the purpose of contraception as immoral. Changes in the New York law applicable to contraception have since taken place which render this decision academic and, in any event, the two recent cases and the Attorney General's opinion discussed herein leave no doubt as to the legality of voluntary sterilization in New York today.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* Current New York State Department of Health policy on family planning services is contained in Executive Memorandum 69-114, dated October 15, 1969, and Field Memorandum 70-70, dated September 15, 1970, and Executive Memorandum 69-10, dated March 5, 1969. The latter urges that family planning services be made available "to all who desire to utilize them . . . without regard for economic or social circumstances . . ."; the memorandum points out that the Department "authorizes state aid reimbursement to local health jurisdictions for family planning programs and services meeting Department standards." Full-time health officers are urged to participate in the promotion of family planning services. The rights of patients and of staff are guaranteed.

Executive Memorandum 69-114 consists of "recommended minimum standards for family planning services." These standards discuss types of providers of service, eligibility, medical referral, ethical considerations relating to participation of health agency personnel, family planning methods, qualifications of physicians, contraindications and precautions, and organization of family planning clinics.

Field Memorandum 70-70 extends the availability of Maternal and Child Health funds to hospitals and Planned Parenthood units as well as to full-time health departments. It states that "reimbursement can be at 100 percent of expenditures, but at the end of the grant period, usually three years, the grantee will be expected to obtain local fiscal support" (except for local health departments). The memorandum stresses hospital participation, and presents essential facts about federal grants available from the National Center for Family Planning Services, DHEW.

2. *Eligibility:* The Department of Health reported in the CFPPD survey that financial, social and geographical eligibility requirements for family planning services, as well as patient fees or payments are determined by local agencies. The references to eligibility in the documents cited above are general and apparently are not considered to be specific recommendations or requirements for local agencies.

3. *Administration:*¹ The Bureau of Maternal and Child Health and Family Planning has administrative responsibility for family planning services in the Department of Health. Professional staff assigned to family planning activities include: two full-time public health physicians; one physician, 25-50 percent time; one physician, 25-50 percent time; one full-time public health educator; and one public health nurse, 25-50 percent time. The Department performs the following functions in support of family planning activities: consultation, training, and grants or contracts to local family planning programs for support of services.

4. *Financing:*² \$452,236 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning services. The total allocation to the state of non earmarked MCH funds for FY 1971 was \$2,199,704. An estimated \$120,000 of these funds were spent for family planning services. For FY 1972 the Department of Health received a \$500,000 appropriation for family planning from the state legislature. Additional state funds utilized by the state health agency for family planning services amounted to \$103,000 in FY 1971.

5. *Voluntary Sterilization:* The Department of health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in New York is contained in Section 386.16 of the Regulations of the Department of Social Services and in Administrative Letter, 71 PWD-82, dated September 9, 1971, under which Section 386.16 was disseminated. Section 386.16 states that "each social services commissioner shall require that appropriate members of his staff personally advise eligible needy persons periodically of the availability at public expense of family planning services." The policy further provided that "each

eligible person desiring family planning services shall be referred for advice and services to his (sic) choice of resource, including approved family planning clinics or private physicians." Authority is established to reimburse providers of medical, social and educational family planning services for services provided "on and after July 1, 1971 on behalf of recipients of AABD [Assistance for the Aged, Blind and Disabled], ADC [Aid to Dependent Children], and also recipients of MA [Medicaid], whose cost of medical care is subject to federal participation." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services *requires* county welfare departments to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients. Section 386.16 states that "recipients shall be assured of choice of method and there shall be arrangements with varied medical resources so that choice of service may be assured."

The policy authorizes reimbursements to hospital outpatient clinics, voluntary agencies and private physicians. Health departments are not authorized to receive reimbursement under the policy. There is no single standard, statewide reimbursement rate for medical family planning procedures.² The Department has no contracts and/or formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as potential recipients of such assistance and residents of low-income areas are eligible for medical family planning services. Applicants and past recipients of such assistance are eligible for referral services only. The Department reported that General Assistance recipients as well as "recipients of Medical Assistance and Child Welfare are also eligible" for medical family planning services. There are no additional limitations that affect the provision of services to adults or minors. Section

386.13 provides that "family planning services and information relating thereto shall be made available without regard to the recipient's marital status, age or parenthood."

4. *Administration:*⁴ Responsibility for the administration of the family planning program is shared by the Office of Medical Program Development and the Office of Social Services Program Development within the Department of Social Services. The Office of Medical Program Development has the major responsibility for training local welfare staff but both agencies apparently develop and distribute public educational materials. One Senior Social Services Consultant (Medical) devotes about 75 percent of his or her time to family planning. An Associate Social Services Consultant (Medical), five Area Medical Consultants and five Area Office Supervising Medical Social Workers spend from 10 to 25 percent of their time on family planning activities. The Deputy Commissioner for Medical Program Development spends less than 10 percent of his or her time on family planning.

5. *Financing:*⁵ The Department of Social Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Social Services has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the New York Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices. No limitation. . . . Reimbursement on basis of applicable fee schedules (i.e. schedules for physicians, clinics, drugs and sick-room supplies)." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)

3. As reported in CFPPD survey.

4. Ibid.

5. Ibid.

North Carolina

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in North Carolina.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority was reduced to 18 years by the 1971 General Assembly. N.C. Gen. Stat. §§ 48A-1; 48A-2 (1971).

Any person who is 18 years of age or older or is emancipated may consent to any medical treatment or health service. N.C. Gen. Stat. § 90-21.5 (a) (1971). In general, parental consent is required for treatment of an unemancipated minor under 18. *Sharpe v. Pugh*, 270 N.C. 598, 155 S.E. 2d 108 (1967). A statutory exception for emergency treatment is discussed below.

A minor is automatically emancipated upon marriage. *Church v. Hancock*, 261 N.C. 764, 136 S.E. 2d 81 (1964). An unmarried minor is emancipated by act of the parent when he surrenders all right to the services and earnings of the child, as well as the right to custody and control of his person. For complete emancipation, the law does not require the severing of all parental ties; a daughter living at home but working and keeping her own wages has been held emancipated. *Gillikin v. Burbage*, 263 N.C. 317, 139 S.E. 2d 753 (1965).

The Attorney General has stated that the burden of proof of a minor's emancipation would rest with a physician in any action brought against him by the parents of a minor treated without parental consent. Opinion of Attorney General, 41 N.C. A.G. 489 (August 19, 1971) (citing *Gillikin v. Burbage*, *supra.*).

A physician may treat a minor without parental consent where the parent or parents, the guardian, or a person standing in loco parentis to the child cannot be located or contacted with reasonable diligence during the time within which the child needs to receive treatment, or where the identity of the child is unknown, or where the necessity for immediate treatment is so apparent that any effort to se-

cure approval would delay the treatment so long as to endanger the life of the minor or where an effort to contact a parent, guardian, or person standing in loco parentis would result in a delay that would seriously worsen the physical condition of the minor. N.C. Gen. Stat. § 90-21.1 (1969 Cum. Supp.)

"Treatment" is defined as any medical procedure or treatment, including surgery, provided that no surgery shall be conducted upon a minor under the emergency provision unless the surgeon shall first obtain the opinion of another licensed physician that said surgery is necessary under the conditions set forth in the statute. However, the opinion of the second physician is dispensed with in an emergency situation arising in a rural community or in a community where it is impossible for the surgeon to contact any other physician. N.C. Gen. Stat. §§ 90.21.2; 90.21.3 (1969 Cum. Supp.)

Any physician administering treatment to a minor under the emergency provisions of the law shall not be liable in damages for having proceeded without permission of parent or guardian. N.C. Gen. Stat. § 90.21-4 (1969 Cum. Supp.)

North Carolina also has a legislative provision that any minor may consent alone with the consent of no other person for diagnosis and treatment of venereal disease. N.C. Gen. Stat. § 90-21.5 (b) (1971).

Moreover, North Carolina has a statute which declares that a child "who is not provided necessary medical care or other remedial care recognized under State law" shall be deemed a "neglected child." N.C. Gen. Stat. § 7A-278 (1969). If the court finds the child to be in need of medical or surgical treatment, the court may allow the parents or other responsible persons to arrange for such care. If the parents decline or are unable to make such arrangements, the court may order the needed treatment and may order the parents or other responsible parties to pay the cost of such care, or if the court finds the parents are unable to pay the cost of such care, such cost shall be a charge upon the county when approved by the court. N.C. Gen. Stat. § 7A-286 (5) (1969).

In the absence of case law in point, it is not clear whether North Carolina courts would accept the "mature minor doctrine" referred to in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

B. Laws Relating to Voluntary Sterilization

A North Carolina statute authorizes and sets forth special procedures for the performance of voluntary sterilization operations on persons 18 years of age or over, or less than 18 years of age if legally married. N.C. Gen. Stat. §§ 90-271 to 275 (1965 and Cum. Supp. 1971).

The surgical procedures authorized are surgical interruption of vas deferens or fallopian tubes. The surgical interruption of fallopian tubes must be performed in a licensed hospital. § 90-271 (Cum. Supp. 1971). The request for sterilization must be made in writing at least 30 days prior to the operation by the person to be sterilized and, if married, also by his or her spouse. There are exceptions to the requirement of spousal consent where: 1) The spouse has been declared mentally incompetent; 2) A separation agreement has been entered into; 3) The spouses are divorced; 4) The wife (to be operated upon) furnishes an affidavit that her husband abandoned her and failed to contribute to her support for at least the preceding six months. § 90-271.

Prior to or at the time of the request for sterilization, a full and reasonable medical explanation must be given by the physician to the patient as to the meaning and consequences of the operation. § 90-271.

The physician or surgeon performing the operation must be duly licensed and must consult or collaborate with at least one other physician or surgeon so licensed. § 90-271. No operation may be performed until 30 days from the date of consent or request therefor nor if the consent is withdrawn. § 90-273 (1965).

The statute exempts licensed physicians and surgeons performing authorized sterilization procedures from civil and criminal liability except for negligence. § 90-274. (1965).

North Carolina also has a statute which provides for the compulsory sterilization of certain mentally defective persons. This statute contains the following provision:

Nothing contained in this article shall be construed so as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this State, by a physician or surgeon licensed in this State, which treatment may incidentally involve the nullification or destruction of the reproductive functions. N.C. Gen. Stat. § 35-52 (1966).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed by a licensed physician or surgeon on a person who is otherwise subject to the provisions of the compulsory sterilization law (i.e., a mental defective), the procedures prescribed in that sterilization law need not be followed although the operation may result in sterilization of the patient.

Moreover, if such an operation is performed on a

person not subject to the provisions of the compulsory sterilization law, the procedures set forth above for voluntary sterilization need not be followed. See N.C. Gen. Stat. § 90-275 (1965).

The State Department of Welfare recommends that local welfare agencies pay for sterilizations for clients who wish them (See Welfare Policy, Sterilization, below).

Minors: We have seen that a North Carolina statute authorizes and sets forth procedures for the voluntary sterilization of any person 18 years of age or over, or less than 18 years of age if legally married. In addition, that statute provides that any licensed physician or surgeon may perform a surgical interruption of the vas deferens or fallopian tubes upon any unmarried person under the age of 18 when so requested in writing by such minor, provided that the juvenile court of the county where the minor resides, upon petition of the parent or parents, if living, or the guardian or next friend of the minor, shall determine that the operation is in the best interest of such minor and shall enter an order authorizing the physician or surgeon to perform such operation. N.C. Stat. § 90-272 (Cum. Supp. 1971).

The physician or surgeon who performs a voluntary sterilization on a minor under the authority of this section must comply with the conditions and requirements for adult sterilization set forth above. The 30 day waiting period, in the case of an infant, runs from the date of the court order, but no operation may be performed if the infant's consent is withdrawn during the 30 day period. § 90-273 (1965).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The North Carolina State Board of Health has no official written policy on family planning, but offers recommendations to local health units: "Since the North Carolina local health departments are autonomous, the ultimate decision as to policies to be adopted and practiced is that of each county. Therefore, the state Board of Health has drawn no statement as to policies. Acting in the capacity of consultant only, it does propose certain recommendations to be used as guidelines to those counties interested in providing this service . . ." [*Recommended Guidelines for Setting Up Family Planning Clinics.*]

The Board's recommendations consist of a document entitled "Proposed North Carolina Family Planning Program (supplemental Section C). Clinical Standards for Contraceptive Service" (undated), which includes state statutory requirements and regulations of the Children's Bureau of DHEW on family planning services, the *Recommended Guidelines* cited above, and a "Syllabus of Contraceptive Service."

2. *Eligibility:*¹ The State Board of Health recommends financial and social eligibility requirements; however, all eligibility requirements are determined by local health agencies. It is recommended that "all persons be provided with family planning service, regardless of financial status,"² and that all adults be considered eligible for services. The Board also recommends that all minors be considered eligible for family planning services, except that unmarried minors are required to have parental consent.³ No geographical eligibility requirements or patient fees are recommended or established by the Board.

3. *Administration:*⁴ The Maternal Health Service, Personal Health Division, has administrative responsibility for family planning in the State Board of Health. The following staff are assigned to family planning activities: the Personal Health Division Director, 10–25 percent time; the Maternal Health Section Chief, 25–50 percent time; one family planning consultant, full-time; one social work coordinator, 10–25 percent time; and one health administrator, 10–25 percent time. The Division performs the following functions in support of family planning activities: consultation; training; development and distribution of public education materials; central data processing (now under development); and limited purchase or provision of supplies, equipment or other materials to local family planning programs. Procedures are now being developed for grants or contracts to local family planning programs for support of services.

4. *Financing:*⁵ \$341,461 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning; \$69,568, or 20.3 percent of these funds were obligated for family planning activities. The MCH unit indicated that "this money was not received until late in the year and it was impossible to spend this amount wisely in the time allocated." The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$1,545,741. An estimated \$75,484 of these funds were spent for family planning services. The State Board of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Board for family planning.

5. *Voluntary Sterilization:* The State Board of Health has no written policy on voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. The Board of Health recommends "that these [family planning] services be primarily for the medically indigent but that they be given to all those who request them but who cannot or will not for some reason obtain them from

a private physician." (*Recommended Guidelines* cited above.)

3. The Board of Health recommends "that those counties considering the responsibility of giving this (family planning) service to the unmarried minor consult their county attorney for legal advice. In the use of the IUD, permits requesting this service should be signed by parents or legal guardian and filed on any unmarried woman under the age of 21 years. In the case of pills for minors who are unmarried or are dependent on parents although married, the implied consent of a patient [parent?] must be gotten and such consent noted on the record." (*Recommended Guidelines* cited above.)
4. Information contained in this section was reported by the state health agency in the CFPPD survey.
5. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in North Carolina is contained in Sections 1400 through 1404, Chapter VII, Volume I of the *Manual* of the Welfare Programs Division of the North Carolina Department of Social Services, dated November 1969. Chapter VII covers such topics as "Initiating Services with the Client," "Safeguarding Against Coercion," "Inter-Agency Cooperation," and establishes standards for written county family planning plans. Part (B) of Section 1402 states that "Each county department's family planning services program is to make provision that in all appropriate instances family planning services shall be offered . . . Consideration must be given as a priority to individuals currently receiving Aid to Families with Dependent Children. In addition, individuals who once received Aid to Families with Dependent Children (former recipients) and those who are likely to become in need of financial assistance (potential recipients) must have the same opportunity as does an active recipient to receive family planning services." Supplement No. 9 to County Letter No. 193, under which Chapter VII was issued, asks county departments to maintain records which will:

- (a) show the number of individuals it refers to the family planning clinic
- (b) record the number of individuals who are referred that actually participate in the family planning clinic
- (c) record the number of individuals who come first to the Department of Health, but are later authorized for family planning services by the Department of Social Services. These statistics will be important, not only to us in future planning and reporting, but also in evaluating the success of the family planning services in each county.

Section 1401 of the *Manual* indicates that the objectives of the family planning program are to help reduce poverty, to improve maternal and child health and to promote family stability.

Additional policy is contained in a 1969 *Inter-agency Agreement for the Provision of Comprehensive Family Planning Services in North Carolina* between the Department of Social Services and the Board of Health under which: "Local health departments, where family planning programs are located, will be responsible for providing medical services, patient education, counseling, and follow-up to individuals referred by the department of social service."

2. *Referral and purchase provisions:*¹ Under the policy, the Department of Social Services *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning resources and to *purchase* medical services for these recipients.

The policy authorizes reimbursements to health departments and private physicians. Hospital outpatient clinics and voluntary agencies are not authorized to receive reimbursement under the policy. There is no single, standard, statewide reimbursement rate for medical family planning procedures.² The Department reported that it has approved contracts and/or other formal arrangements entered into by local welfare agencies with local providers of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance as well as past recipients (2 years) and potential recipients of Aid to Families with Dependent Children (AFDC) assistance are eligible for medical family planning services. The Department reported that unless applicants for AFDC and residents of low-income areas as well as applicants and past recipients of other assistance programs are "receiving medical assistance," they are eligible for referral services only. General Assistance recipients are eligible for medical family planning services. The Department of Social Services has no additional limitations that affect the provision of services to adults or minors, but reported that individual policies of local health departments may affect the availability of family planning services for minors.

4. *Administration:*⁴ The Family and Children's Ser-

vices Section of the Division of Welfare Programs in the State Department of Social Services is responsible for the administration of the family planning program. There is one full-time Supervisor of Family Planning Services in the Family and Children's Services Section. In addition, the Supervisor of the Section and 21 Consultants spend from 10 to 25 percent of their time in family planning activities. Activities include the training of local welfare staff as well as supervisory and consultative duties.

5. *Financing:*⁵ There is a specific state appropriation for family planning services in the North Carolina Department of Social Services. In the state's last fiscal year, which ended June 30, 1971, there was an appropriation of \$93,750 to the Department of Social Services to be used as matching funds for Title IV-A services. The \$93,750 represents the amount of state money that was available to match family planning expenditures of local welfare departments.

6. *Voluntary Sterilization:* The Department of Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local welfare agencies. The Department, however, *recommends* that local agencies *purchase* sterilization for eligible recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the North Carolina Medicaid program family planning services are "Provided. No limitations. . . . Reimbursement to institutions on basis of reasonable cost (Medicare cost reimbursement principles); to practitioners on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69)." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey unless otherwise noted.
4. Ibid.
5. Ibid.

North Dakota

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in North Dakota.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* North Dakota has a statute which prohibits the sale or distribution by vending machine of drugs, medicines or devices for the prevention of disease or pregnancy. N.D. Cent. Code § 12-43-12 (1960).

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* Minors are persons under 18 years of age. N.D. Cent. Code § 14-10-01 (1971).

A parent's authority over a child ceases upon the child's attaining majority, upon the marriage of a child, or upon the appointment by a court of a guardian of a child. N.D. Cent. Code § 14-09-20 (1971). Another statute provides an additional means of emancipating a child from parental authority: "The parent . . . may relinquish to the child the right of controlling him and receiving his earnings. Abandonment by the parent is presumptive evidence of such relinquishment." N.D. Cent. Code § 14-09-17 (1971).

No cases were found dealing with a minor's right to consent to medical services. However, when by statute, parental authority over a child ceases, or the parent relinquishes his right of control over a child, the child can presumably consent to his or her own medical care.

Thus a married minor undoubtedly could consent to his or her own medical care. Males at 18 and females at 15 are capable of consenting to marriage. Males younger than 21 or females younger than 18 need parental consent in order to be issued a marriage license.¹

Any person 14 or older may contract for and receive examination, care or treatment for venereal disease without permission, authority or consent of a parent or guardian. N.D. Cent. Code § 14-10-17 (1971).

We have found no cases or Attorney General opinions indicating whether North Dakota courts follow the general pattern of permitting medical

treatment for minors without parental consent in emergencies or whether North Dakota would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

The welfare department requires parental consent only for individuals younger than 18 and unmarried. (See "Welfare Policy," "Eligibility," below.)

Under North Dakota law, any person or parent legally responsible for the care or support of a child younger than 18 who "wilfully fails to furnish . . . medical attention reasonably necessary and sufficient to keep the child's life from danger and discomfort and his health from injury is guilty of a felony." N.D. Cent. Code § 14-47-15 (1971). A parent who "wilfully neglect[s] or refuse[s] to provide . . . necessary care for the health, morale or well-being" of a child younger than 18 is also subject to civil penalties. N.D. Cent. Code § 14-09-22 (1971).

Footnote:

1. The reduction of the age of majority to 18 would appear to render obsolete the requirement of parental consent for males of 18 or older.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Milde v. Leigh, 75 N.D. 418, 28 N.W. 2d 530 (1947), was an action for damages by a husband against a physician who had agreed to perform a sterilization operation on his wife in connection with a caesarean section. Some time later the wife became pregnant again and was required to undergo a second caesarean operation. The complaint alleged that the sterilization operation had been negligently performed and as a result, the plaintiff incurred medical expenses and lost the services and companionship of his wife for a long period. The court held that the action was not barred by the statute of limitations. The court assumed that there was no question about the legality of voluntary sterilization.

The CFPPD survey indicates that the Department of Social Services authorizes referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients who wish them (See

Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current written policy on family planning of the State Department of Health consists of a *Statement of Policy Regarding Family Planning*, dated July 28, 1971. The statement is as follows:

We accept and respect the right of husband and wife to plan for the number of their children.

Upon the request of any local health unit we will assist in the provision of family planning services within our capabilities.

Any family planning program is to be voluntary on the part of the recipient and is not to be a prerequisite for eligibility to receive any other services provided through the use of Federal health funds.

2. *Eligibility:*¹ Financial, social and geographical eligibility requirements, as well as patient fees or payments, are determined solely by local health agencies.

3. *Administration:*² The Division of Maternal and Child Health has administrative responsibility for family planning services in the State Department of Health. Staff assigned to family planning activities include: one public health nurse, 10–25 percent time and one secretary, 10–25 percent time. The state health agency performs the following functions in support of family planning activities: consultation and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$11,431 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$205,130. An estimated \$15,844 was spent for family planning services. The State Department of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Department for family planning services.

5. *Voluntary Sterilization:* The State Department of Health has no written policy on voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare fam-

ily planning policy in North Dakota is contained in Chapter 319, Section 9 of the *Social Work Manual* of the Department of Social Services, dated February 1968. Paragraph 3 of Section 9 states: "County welfare board directors, social workers, caseworkers, and Area Social Service Center personnel are responsible for furnishing appropriate family planning information when requested by recipients of public assistance and/or social services." According to paragraph 1 of Section 9 family planning is "a means of promoting and safeguarding the general health of people with whom the program deals and of strengthening the integrity of families by providing sufficient information to assure freedom of choice about having children."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services requires local welfare agencies to *refer* eligible public assistance recipients to medical family planning sources and to *purchase* medical family planning services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics and private physicians. Health departments and voluntary agencies are not authorized to receive reimbursement under the policy. There is no single standard, statewide reimbursement rate for medical family planning procedures.² The Department has no contracts and/or formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for counseling and referral services only. The Department reported that the provision of medical family planning services to recipients of General Assistance is a matter of "local option."

Paragraph 3 of Section 9 states that "unattached women—those divorced or separated from their husbands and mothers of children born out-of-wedlock—will sometimes request or be receptive to information concerning family planning services. All policies expressed throughout this section apply equally to such persons." The Department reported that the "parent, individual, or agency having custody must give permission if the individual is under age 18 and unmarried" and wishes to receive family planning services.

4. *Administration:*⁴ The Social Service Unit in the Department of Social Services has administrative responsibility for the family planning program. No staff are assigned either full- or part-time to family planning. The family planning activities of the Unit include the training of local welfare staff through

statewide workshops and the development and distribution of education material.

5. *Financing*:⁵ The Department of Social Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *authorizes referral* for the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish it.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the North Dakota Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices. Separate authorization by county welfare board for services of each provider utilized (e.g., physician, clinic, pharmacist). Basis of reimbursement variable according to provider utilized." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Ohio

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Ohio has a statute directing the county administration for aid to dependent children to refer the mother of a child receiving such aid who is living with the child to a private or public agency, doctor, clinic or organization where she can receive family planning information. The administration may procure for such mothers any contraceptives needed or desired by them. Ohio Rev. Code Ann. § 5107.10 (1970).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* In 1965 Ohio deleted reference to the sale and advertising of articles "for the prevention of conception" from its Criminal Code.¹ Thus, there is now no state law restricting or regulating the sale or distribution of contraceptive drugs or appliances.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found (See above).

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. Ohio Rev. Code Ann. § 3109.01 (1960).

A minor can consent to diagnosis or treatment of any venereal disease by a licensed physician. Ohio Rev. Code § 3709.241 (Supp. 1972).

In *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E. 2d 25 (1956), a majority of four judges of the Ohio Supreme Court, in a concurring opinion, adopted the "mature minor doctrine." The plaintiff in that case had plastic surgery on her nose when she was 18. She later claimed that the surgeon had no right to proceed without her parents' consent. The lower court entered judgment on a verdict for the plaintiff. An intermediate court reversed. On appeal to the Ohio Supreme Court, the judgment of the intermediate court was affirmed. Three judges stated that the affirmance was based on the ground that the lower court judge gave incorrect instructions as to damages. However, four judges joined in a concurring opinion, which said:

A charge that this 18-year-old plaintiff could not consent to what the jury could have found was only a *simple operation*, would seem inconsistent with the conclusion of our General Assembly, that any female child of 16 can prevent the taking of liberties with her person from being

raped merely by consenting thereto at the time such liberties are taken....

My conclusion is that performance of a surgical operation upon an 18-year-old girl with her consent will ordinarily not amount to an assault and battery for which damages may be recoverable even though the consent of such girl's parents or guardian has not been secured. 139 N.E. 2d at 34.

The majority in *Lacey v. Laird*, see above, rejected the traditional view that the validity of consent to medical care depends on the consenting party's capacity to contract. Instead, the judges used analogies from the fields of criminal and tort law, such as the age at which a person can be held responsible for criminal conduct and can "assume the risk" in a negligence case. The court relied on cases holding that minors of sufficient intelligence and maturity could not recover damages for injuries resulting from hazards to which they voluntarily exposed themselves. Since *Lacey v. Laird*, a mature minor may consent to medical treatment in Ohio even though not "emancipated."²

Ohio has a statute defining a neglected child which includes any child whose "parents, guardian, or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals, or well being." Ohio Rev. Code Ann. § 2151.03 (Supp. 1970). Upon the certification of one or more reputable practicing physicians, the juvenile court may summarily provide for emergency medical and surgical treatment which appears to be immediately necessary for any child concerning whom an application has been filed. Ohio Rev. Code Ann. § 2151.33 (1968).

In 1962, an Ohio court overruled a motion by two parents, both Jehovah's Witnesses, to vacate an emergency order authorizing a blood transfusion for their severely burned three-year-old child. *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E. 2d 128 (1962). In 1969, Section 2151.03 (quoted above) was amended by addition of the following language:

(e) A child who, in lieu of medical or surgical care or treatment for a wound, injury, disability, or physical or mental condition, is under spiritual treatment through prayer in accordance with the tenets and practices of a well-recognized religion, is not a neglected child for this reason alone.

The *Clark* case would seem still to be good law,

however, for two reasons. First, the court based its decision not only on the statute but on its broad equitable powers. Second, the last four words of the new section—"for this reason alone"—indicates that a doctor's certification that the child is in emergent need of medical or surgical care would warrant a finding of neglect even where the child is under spiritual treatment through prayer.

We have seen that by statute the county administration for aid to dependent children may procure for the mother of any needy child receiving aid to dependent children, if such mother is living with the dependent child, any pills or devices needed and desired by such mother for the control of conception (See *Laws Establishing Family Planning Programs*, above).

Although minor mothers would seem to be included by this statute, in the absence of cases in point it is not clear whether the statute abrogates any requirement of parental consent. The state health agency policy guidelines state that services must be available to all women who desire family planning services regardless of age, marital status or maternity status. The welfare department requires parental consent for services to minors who are not married or emancipated (See *Welfare and Health Policy, Eligibility*, below).

Footnotes:

1. Ohio Rev. Code Ann. §§ 2905.32, 2905.33 and 2905.34. § 2933.21, which allows a judge to issue a search warrant for instruments for the prevention of conception, has not been repealed or amended. However, now that there is no longer any restriction on the distribution or advertising of contraceptives, the validity of a warrant issued to seize a lawfully held item would certainly be open to question.
2. There are numerous Ohio cases defining "emancipation" for various purposes other than consent to medical care. The burden of proving emancipation is on the party who asserts it. *Bagyi v. Miller*, 3 Ohio App. 2d 371, 210 N.E. 2d 887 (1965); *Seitz v. Witzberger*, 18 Ohio Cir. Ct. Rep. (New Series) 160 (1911), aff'd without opinion, 88 Ohio St. Rep. 579, 106 N.E. 1076 (Ohio Sup. Ct. 1913). It seems clear that a minor is emancipated by marriage. *Schulman v. Villensky*, 103 Ohio App. 300, 143 N.E. 2d 754 (1957). This is so even when the minor marries below the legal age of consent (as long as she is over 12, the common law age of consent). *Klinebell v. Hilton*, 2 Ohio L. Abs. 637 (Ohio App. 1924). An 18-year-old who works and is self-supporting may be emancipated even though living at home. *Townsen v. Townsen*, 101 Ohio App. 85, 137 N.E. 2d 789 (1954). Ohio has a statutory procedure whereby a minor who has been injured by wrongful act or neglect and seeks to recover damages may apply to the probate court for a finding that the minor is emancipated. Ohio Rev. Code Ann. § 2111.181 (1968).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision in Ohio which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The case of *In re Simpson*, 8 Ohio L. Abs. 193, 180 N.E. 2d 206 (Probate Ct. Zanesville Co. 1962), upheld the power of a judge to order sterilization as a contraceptive procedure for a feeble-minded girl on the request of her mother. Even though Ohio has no statute providing for the compulsory sterilization of mental defectives, the Ohio Probate Court, under its general statutory and equity powers to provide for the care and maintenance of the feeble-minded, ordered that a salpingectomy be performed on Nora Ann Simpson, an 18-year-old feeble-minded girl who had already given birth to one illegitimate child.

The court said:

It is the opinion of the court that the welfare of both Nora Ann Simpson and society would best be served by having an operation performed which would prevent further pregnancies. Such an operation, termed medically "salpingectomy," can be safely performed by any qualified surgeon. To deny Nora Ann such an operation would be to condemn her to a lifetime of frustration and drudgery, as she continued to bring children into the world for whom she is not capable, either physically or mentally, of providing proper care. 180 N.E. 2d at 208.

However, in *Wade v. Bethesda Hospital*, 337 F. Supp. 671 (S.D. Ohio 1971), a Federal District Court criticized the *Simpson* decision. The *Wade* case was brought against several defendants including Judge Holland Gary, the probate judge who ordered Nora Ann Simpson's sterilization and also the sterilization of the plaintiff in *Wade*, another mentally retarded girl. The Federal District Court held in the *Wade* case that Judge Gary acted outside the scope of his jurisdiction and could be sued for damages by the girl whose sterilization he ordered.

While both of these cases deal with the sterilization of incompetents (which is not covered by this study), they are relevant since they indicate that Ohio has no public policy against sterilization as such.

As stated above, Ohio has a statute authorizing the county administration for aid to dependent children to refer mothers of a child receiving such aid who are living with the child for family planning information, and to "procure for such mothers any pills or devices needed and desired by such mothers for the control of conception." (See *Laws Establishing Family Planning Programs*, above). While it is not clear whether this statute includes voluntary sterilization, the 1971 CFPPD survey indicates that the Department of Public Welfare requires referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients who wish them. (See *Welfare Policy, Sterilization*, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The Ohio Department of Health policy on family planning con-

sists of *State Guidelines for Family Planning*, issued by the Division of Maternal and Child Health, May 1971. The *Guidelines* set forth requirements for applications to the MCH Division for MCH funds for family planning services. The *Guidelines* describe eligible applicant agencies and requirements for the content of project applications. Any public or private agency is eligible to apply for MCH funds. Project proposals must contain statements of objectives, community needs and background, and service delivery procedures. The *Guidelines* establish requirements for clinical examinations, social and medical history, educational services, social services, recruitment and follow-up, and treatment of medical problems incidental to family planning. Policies on voluntarism, eligibility, patient fees, interagency coordination, project evaluation, budget requirements and fiscal accountability are described.

2. *Eligibility*: The *Guidelines* state that in programs applying for state health agency funding, "services must be available on a voluntary basis to all women who desire family planning services regardless of age, sex (sic), marital status, maternity status, residency, race, creed, color, and income level. Fees may be charged on a sliding scale basis for those who are able to pay. Free services should be available for those who are unable to pay."

3. *Administration*:¹ The Division of Maternal and Child Health has administrative responsibility for family planning services in the Department of Health. Staff assigned to family planning services include a full-time nursing consultant and a full-time social services consultant. The Department performs the following functions in support of family planning activities: consultation; training; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and consultation services to local agencies in developing OEO and DHEW grant proposals.

4. *Financing*:² \$393,156 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning; \$383,000, or 97.2 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$1,867,731. An estimated \$407,000 of these funds were spent for family planning services. The state health agency received no specific appropriation for family planning from the state legislature in FY 1971. The Department of Health used an unspecified amount of general health department funds for family planning services in FY 1971.

5. *Voluntary Sterilization*: The Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Ohio is contained in Section 32.2, Chapter 30 of the *Social Services Manual* of the Department of Public Welfare, dated July 1971. Section 32.2 states that family planning services are "especially important as preventive services for teenagers who may have children before they are prepared to handle responsibilities of child rearing, and to parents with child rearing problems who may become abusive or neglectful." Family planning program objectives as established by Section 32.2 are "to provide every person with opportunities to determine the number of children he or she desires, including opportunities for control and spacing of births; and to promote the health of mothers and children by reducing the incidence of mortality, morbidity, prematurity, congenital defects, mental retardation and unwanted pregnancies." Payment policy for family planning services is found in Sections 722.4 and 751.1 of the Medicaid Regulations in the *Public Assistance Manual*.

2. *Referral and Purchase Provisions*:¹ Under the policy, the State Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning resources and to *purchase* medical family planning services for these recipients.

The policy authorizes reimbursement to hospital outpatient clinics, health departments, voluntary agencies and private physicians. However, Section 722.4 states that "payment is not made for professional services provided in a planned parenthood agency but drugs and supplies may be provided." There is no single, standard statewide reimbursement rate for medical family planning procedures.² The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as applicants, past recipients, and potential recipients of such assistance, residents of low-income areas, and recipients of general assistance, are eligible for medical family planning services.

There are no additional limitations that affect the provision of services to adults. Section 32.2 provides that "family planning services must be provided to all individuals who desire them, regardless of age,

parenthood or marital status." However, despite this language and the above quoted sentence emphasizing the importance of family planning services to teenagers, the Department reported that parental consent is required for the provision of services to minors except those who are married or emancipated.

4. *Administration*:⁴ The Division of Social Services has administrative responsibility for the family planning program in the Department of Public Welfare. One Service Coordinator, one Program Development Specialist, and one Technical Assistance Specialist in the Division spend from 10 to 25 percent of their time in family planning activities. Family planning activities of the Division include the training of local welfare staff, the development and distribution of public educational materials, and assistance to county welfare departments in developing family planning contracts.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *requires referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Ohio Medicaid program family planning services are "Provided. Including drugs, supplies and devices. No limitations. . . . Reimbursement of physicians on basis of 60 percent of usual, customary, and reasonable fees; of pharmacists on basis of wholesale cost plus 50 percent, but total not to exceed charges to general public. Nominal fee paid to planned parenthood agencies for drug supplies and devices." The 1970 City University of New York study reported that \$45,868 was expended for contraceptive drugs and devices by the Ohio Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures were \$90,000. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Oklahoma

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: In 1967 the Oklahoma legislature passed a law declaring "family planning services" to be essential to the health and welfare of the citizens of Oklahoma. "Family planning," as defined by the statute, encompasses "the spacing of children and infertility or sterility in husbands and/or wives." (Okla. Stat. tit. 63, § 2071 (Supp. 1967)).

The statute authorizes the State Department of Health to establish "Family Planning Centers," and declares: "These centers may be operated as a part of the services of a County, District, Cooperative or City-County Department of Health, or may be operated directly by the State Department of Health, or by the State Department of Health in cooperation with nongovernmental agencies or organizations." Okla. Stat. tit. 63, § 2072 (Supp. 1967).

The Family Planning Centers are required to be under the direction of a licensed physician and to furnish educational materials and information "with respect to achieving a planned parenthood, including advice as to contraceptive practices, medical surgery devices and pharmaceuticals." Centers are also authorized to carry out clinical activities incident to child-spacing, including medical examinations, insertions of contraceptive devices and prescriptions of drugs. Drugs and devices may be furnished to eligible persons. § 2073.

The State Board of Health is authorized to promulgate rules, regulations and standards for the operation of the Centers, such as eligibility criteria, and a fee schedule so that those applicants able to pay for services and devices and supplies will do so. § 2074.

The Department of Public Welfare is required to provide "educational materials and information with respect to achieving a planned parenthood" to any person on welfare who so requests it, or to refer that person to a family planning center or organization where he or she can get such information. The Department of Public Welfare is authorized to pay private medical and osteopathic physicians for their services in furtherance of such "planned parenthood." Okla. Stat. tit. 56, § 28.1 (Supp. 1967).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

3. *Laws and Court Decisions Relating to Dissemina-*

tion of Information, Advertising and Display Respecting Contraceptives: None found.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 21 for males and 18 for females. Okla. Stat. Ann. tit. 15, § 13 (1966).

The district courts have statutory authority to confer upon minors the rights of majority concerning contracts and other matters. Okla. Stat. Ann. tit. 10, § 91 (1966). Moreover, by statute in Oklahoma the authority of a parent ceases upon the marriage of the child. Okla. Stat. Ann. tit. 10, § 10 (1966). A married minor can, therefore, enter into a contract related to medical expenses. *Daubert v. Mosley*, 487 P. 2d 353 (Okla. Sup. Ct. 1971).

Another Oklahoma statute provides that a parent may relinquish to the child the right of controlling him and receiving his earnings. Abandonment by the parent is presumptive evidence of such relinquishment. Okla. Stat. Ann. tit. 10, § 17 (1966). A 16-year-old boy whose mother died and whose father told him he would have to do for himself as best he could, and who lived and worked away from home, has been held emancipated. *Harris Irby Cotton Co. v. Duncan*, 57 Okla. 761, 157 P. 746 (1915).

Minors regardless of age can consent to examination and treatment by a licensed physician for any venereal disease. Okla. Stat. Ann. tit. 63, § 1-532.1 (Cum. Supp. 1971).

Although in an emergency a physician may treat a minor without waiting for parental consent, the burden of proving that an emergency in fact existed is on the physician. *Rogers v. Sells*, 178 Okla. 103, 61 P. 2d 1018 (1936). Oklahoma has a "Good Samaritan" statute which protects from civil damages any licensed practitioner of a healing art who in good faith renders emergency care or treatment at the scene of the emergency. The same statute provides that "no person who is a licensed practitioner of a healing art in the State of Oklahoma shall be prosecuted under the criminal statutes of this State for treatment of a minor without the consent of a minor's parent or guardian when such treatment was performed under emergency conditions and in good faith." Okla. Stat. tit. 59, § 518 (1971).¹

No cases were found indicating whether Oklahoma courts would accept the "mature minor doctrine" described in the Summary and Analysis of

State Laws Relating to Contraceptive Services to Minors.

An Oklahoma statute defines as a "dependent or neglected child" any person younger than 18 "who is in need of special care and treatment because of his physical or mental condition, and his parents, guardian or legal custodian is unable to provide it Provided, however, no child who, in good faith, is being provided with treatment and care by spiritual means alone in accordance with the tenets and practice of a recognized church . . . shall, for that reason alone, be considered to be a dependent or neglected child . . ." Okla. Stat. Ann. tit. 10, § 1101 (c) (Cum. Supp. 1971). When a petition has been filed alleging that a child is dependent or neglected or delinquent and the child appears to be in need of nursing, medical or surgical care, the court may order the parent to provide such care in a hospital or otherwise. If the parent fails to provide such care, the court may enter an order to provide the care. "In an emergency the court may, when health or condition of the child may require it, cause the child to be placed in a public hospital or institution for treatment or special care, or in a private hospital or institution which will receive it for like purpose, and consent to emergency treatment for surgery." Okla. Stat. Ann. tit. 10, § 1120 (Cum. Supp. 1971).

We have seen that the State Department of Health is authorized to establish family planning centers and further that the State Board of Health is authorized to promulgate rules and standards as to the "eligibility of persons for service." Also, whenever "a person receiving public assistance" requests it, the Department of Public Welfare shall furnish educational materials and information or refer such person to a family planning center, organization or agency (See *Laws Establishing Family Planning Programs*, above).

In the absence of cases in point, it is not clear whether this statute abrogates any requirement of parental consent. The Health Department apparently does not require parental consent where the minor is referred by a recognized agency, clergyman, nurse or doctor. (See *Health Policies, Eligibility*, below).

Footnote:

1. No cases were found involving criminal prosecution of a doctor for treatment of a minor without the consent of the minor's parent or guardian. However, this statute was probably designed to protect the physician against charges of criminal assault and battery. In *Rogers v. Sells*, discussed in the text, a physician who, without obtaining parental consent, amputated the foot of a 14-year-old boy whose leg had been crushed in an automobile accident was held civilly liable for assault and battery.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of compe-

tent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

We have seen that Oklahoma has a 1967 statute authorizing the State Board of Health to set up Family Planning Centers which shall advise people as to "contraceptive practices, medical surgery devices and pharmaceuticals." The Centers are also authorized to "carry out clinical activities incident to child spacing," (See *Laws Establishing Family Planning Programs*, above). It is not stated whether the "medical surgery" services authorized refer to voluntary sterilization.

Oklahoma has a statute which provides for the compulsory sterilization of certain insane persons and habitual criminals. This statute contains the following provision:

Nothing in this Act shall be so construed as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this state, by a physician or surgeon licensed by this state, which treatment may, incidentally, involve the nullification or destruction of the reproductive organs. Okla. Stat. Ann. tit. 43A, § 346 (1954).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed on a person who is otherwise subject to the provisions of the compulsory sterilization law, the procedures prescribed in that law need not be followed although the operation may result in sterilization of the patient.

The Department of Health has a written policy in regard to voluntary sterilization which encompasses referrals and provision of or payment for sterilization services for females and males. (See *Health Policy, Sterilization*, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The current written policy on family planning of the State Department of Health consists of a policy statement entitled "Family Planning," adopted by the State Board of Health, December 10, 1967 (pursuant to Okla. Stat. §§ 2071-2075, tit. 63, (Supp. 1967), and a set of guidelines issued by the Maternal and Child Health Division in June 1969 entitled, *Guidelines for Family Planning Programs*. The policy statement on family planning states that "it is the policy of the State Department of Health that family planning services be included in the public health services provided by local health departments." The policy statement guarantees against coercion and guarantees a choice of contraceptive methods to potential patients.

The guidelines assign responsibility for family planning to the medical director of each county health department. Standards are included in the guidelines for eligibility, fees, and clinic procedures.

2. *Eligibility*: "All persons applying to health department clinics" for family planning services "shall be eligible" for information and counseling regardless of income. "Applicants will be either admitted to service or referred to other resources. . . . Those applicants financially able to pay will be encouraged to seek [medical family planning] service from private physicians or clinics." (*State Department of Health policy statement*, December 1967.) All categories of adults apparently are eligible for family planning services; no exclusions were noted in the CFPPD survey and none appear in the written policies. According to the Division of Maternal and Child Health's *Guidelines for Family Planning Programs*, "minors may be accepted for services if: 1) ever married or ever pregnant; 2) bearing acceptable proof of impending marriage; 3) accompanied by parent or guardian requesting services; 4) referred by a recognized agency, a doctor, a nurse, or a clergyman . . . [However,] contraceptive *advice* may be given in *all* cases where the health needs of the patient make it advisable . . ." (first emphasis added). The only geographical eligibility requirement recommended by state health policy is that patients live in the area of the facility; there is no requirement for legal residence (CFPPD survey). As of the Spring of 1971, the "general policy" on patient fees is that there will be no charge made for services (CFPPD survey).

3. *Administration*:¹ The Maternal and Child Health Division has administrative responsibility for family planning services in the Department of Health. The following staff are assigned to family planning activities: the Director of Maternity Services, 25–50 percent time; the Director of Family Planning Field Services, full-time; one full-time secretary; three secretaries, 25–50 percent time; one staff assistant, 25–50 percent time; seven family planning coordinators, full-time; the Director, Division of Maternal and Child Health, 10–25 percent time; one public health nurse, full-time; one public health statistician, 25–50 percent time; one social work consultant, 10–25 percent time; one psychological consultant, less than 10 percent time; one nutritionist, 25–50 percent time; three social workers, full-time; and one social worker, 25–50 percent time. The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and personnel services to local health department employees.

4. *Financing*:² \$112,783 of new MCH funds were allocated to the state in FY 1971 which were federally

earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$494,057. An estimated \$32,114 of these funds were spent for family planning services. The state health agency received a \$200,000 appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the state health agency for family planning services.

5. *Voluntary Sterilization*:³ According to the Division of Maternal and Child Health, the Department of Health has a written policy in regard to voluntary sterilization which encompasses referrals and provision or purchase of sterilization services for females and males.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
3. Information contained in this section was reported by the state health agency in the CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Oklahoma is contained in Section 625 of the *Policy and Procedure Manual* of the Bureau of Children's Services, dated May 1969. Section 625 states: "Family planning services promote responsible parenthood, strengthen the health and social competence of the family, and permit each family the freedom to determine the spacing and number of children within their family unit. . . . Each family has a right to the opportunity to understand how family planning can help reach its own goals for health, economic stability and general welfare."

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Institutions, Social and Rehabilitative Services *recommends* that local welfare agencies *refer* eligible public assistance recipients to medical family planning services, and also *recommends* but does not require that local welfare agencies *purchase* family planning services for these recipients. The Department reported that it "pays for services in organized hospital outpatient clinics with whom we have a contract and to private physicians. Rate in O.P. clinics for all services rendered in one day regardless of number of clinics visited—\$12.50. Private physicians are paid the usual and customary fee within prevailing scale."²

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family plan-

ning services. There is no information as to whether applicants, past recipients and potential recipients of such assistance and residents of low-income areas are eligible for family planning services. General Assistance recipients are, however, eligible for medical family planning services.

Section 625 states that "In two-parent families, the worker will discuss family planning with both the father and mother as it is most important that both participate in making the decision and following through in the plan." There are no other limitations that affect the provision of services to adults. Section 625 provides that "services must be made available without regard to marital status, age or parenthood." However, the last sentence of Section 625 states: "when an unwed teenager is in need of family planning services and is living in the parental home, the parents are included in the discussion."

4. *Administration*:⁴ Responsibility for the administration of the family planning program is shared by the Medical Assistance Division and the Bureau of Children's Services. Two professional staff members spend less than 10 percent of their time in family planning activities. Family planning activities of the two agencies include the training of local welfare

staff and the development and distribution of public educational materials.

5. *Financing*:⁵ The Department of Institutions, Social and Rehabilitative Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Institutions, Social and Rehabilitative Services has no written policy on voluntary sterilization, but the Department reported in the CFPPD survey that it "does not provide sterilization services."

Footnotes:

1. Unless otherwise indicated, information in these sections was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Oklahoma Medicaid program, family planning services are "not provided." However, this publication is based on data as of January 1970 and the Oklahoma Medicaid program may have been modified since that date. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in the CFPPD survey.
4. Ibid.
5. Ibid.

Oregon

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* A 1971 Oregon law permits physicians to provide birth control information and services to any person without regard to the age of such person. Ch. 381 [1971] Oregon Laws 551 (See *Laws on Contraceptive Services to Minors*, below).

Oregon has, in addition, a statute which *requires* every county Health Department and *permits* any county Welfare Department to offer family planning and birth control services, within the limits of available funds, to "persons"¹ whose family income does not exceed \$6,000. Ore. Rev. Stat. § 435.205 (as amended by Ch. 396 [1971] Oregon Laws 571). Family planning services may include interviews, distribution of information and literature, referrals to doctors for consultation, examination, medical treatment and prescription, and to the extent so prescribed distribution of rhythm charts, an initial supply of contraceptive drugs, medicines or contraceptive devices and similar products. If the welfare department caseworkers initiate discussion on family planning with interested welfare recipients, then the county health department is not required to seek out interested persons.² The refusal of any person to accept family planning services does not affect his or her right to receive public assistance or benefits.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Under Oregon law, appliances or drugs for the prevention of conception or venereal disease cannot be displayed, sold or otherwise disposed of without a license. Ore. Rev. Stat. §§ 435.010 to 435.130 (1969). An exception in the statute exempts licensed medical practitioners. There are three kinds of licenses: Wholesale, Retail pharmacy, and Manufacturing. Wholesale and Manufacturing licenses may be issued only to persons authorized to sell or distribute contraceptives. Holders of these licenses may sell only to other licensees under this statute or to licensed medical practitioners. Retail pharmacy licenses may be issued only to licensed pharmacies. Sales under this license may be made only from the prescription department, and by a licensed pharmacist. The statute prohibits the sale or distribution of contraceptives or prophylactics by vending machines or house to house or street solicitation.

A 1966 Attorney General's opinion, interpreting this statute, stated that even though oral contraceptives are used for several other purposes besides the control of conception, they have a special utility for preventing conception and thus fall within the purview of the statute. Accordingly oral contraceptive pills may be sold or otherwise disposed of only by physicians (since they are specifically exempted from the provisions of the statute) and by pharmacies licensed pursuant to chapter 435; wholesalers, distributors and manufacturers of the pills must obtain suitable licenses as well. Op. Atty. Gen. 1966, No. 6090.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* "Discreet and tasteful" advertising of contraceptives and prophylactics is permitted under Oregon Law. Ore. Rev. Stat. § 435.110. However, this same section prohibits the display or exposure for sale of these articles.

A 1971 opinion by the Attorney General construed § 435.110, which was amended in 1969. Before its amendment, the section prohibited the display of contraceptives and prophylactics and their packages, and the advertisement of such articles. Under the statute as amended, the display of articles themselves is illegal, but, the Attorney General said, it is not illegal to display them in their containers or packages as long as the articles themselves are not visible, since "discreet and tasteful advertising" is permitted under the amended statute. Op. Atty. Gen. 1971, No. OP-0227.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. Ore. Rev. Stat. § 109.510 (1969). However, all persons attain majority upon marriage. Ore. Rev. Stat. § 109.520 (1969). Minors at age 18 may enter into valid and binding contracts. Ch. 726 [1971] Oregon Laws 1924. While contraceptives may be given to persons of any age (see *Laws on Contraception*, above), there appears to be a requirement for parental consent for minors younger than 15. The statute provides that "any physician may provide birth control information and services to any person without regard to the age of such person and a minor 15 years of age or older, may give consent to medical or surgical diagnosis or treatment by a [licensed] physician . . . with-

out the consent of a parent or guardian." But minors may not consent to an abortion. Ch. 381 [1971] Oregon Laws 551. The physician may advise the parent or legal guardian of diagnosis or treatment without the consent of the patient. *Ibid.*

A minor 12 years of age or older who may have come into contact with any venereal disease may consent to diagnosis or treatment of such disease, without the consent of a parent or guardian. Ore. Rev. Stat. § 109.105 (1969).

Footnotes:

1. Before a 1971 amendment, the category of people to be served was limited to "parents".
2. Presumably then, if the Welfare Department is not initiating discussions on family planning, the Health Department is required to seek out interested qualified persons.

B. Laws Relating to Voluntary Sterilization

Oregon has a statute which provides as follows:

Voluntary sterilization authorized; use of licensed hospital
—A person may be sterilized by appropriate means upon his request and upon the advice of a physician licensed by the State Board of Medical Examiners. Ore. Rev. Stat. § 435.305 (1969).

This statute clearly authorizes voluntary sterilization upon request and upon the advice of a licensed physician.

Prior to a 1969 amendment, this statute contained a requirement that sterilization procedures be performed in a licensed hospital. When this requirement was eliminated, the caption of Section 435.305 was not changed to delete the words "use of licensed hospital." The continued presence of these words in the caption would seem, however, to be a mere anachronism; the statute does not now require use of a licensed hospital.

The United States District Court for the District of Oregon recently handed down a decision in the case of *Chrisman v. Sisters of St. Joseph of Newark*, Civ. No. 70-430 (U.S. D. Ct. D. Ore. 1971). Mrs. Chrisman, having decided, for socioeconomic reasons, to bear no more children following the termination of her then current pregnancy, requested that defendant hospital allow her doctor to perform a tubal ligation during her forthcoming maternity hospitalization. The hospital refused. Mrs. Chrisman thereupon brought suit for damages and for an order compelling the hospital to permit the surgery. During pretrial proceedings, she obtained the desired sterilization at another hospital. The defendants moved for summary judgment, claiming among other things that the action had become moot. The court refused to give judgment for the defendants, holding that Mrs. Chrisman still had a claim for damages and that she presented in good faith a question of substantial public interest. The court held that the hospital, which receives public

funds under the Hill-Burton Act, is "affected with state action, and therefore cannot engage in racial or other arbitrary forms of discrimination when deciding which patients and physicians to admit to the hospital."

The court ruled that a trial was necessary to determine whether the hospital was truthful in asserting that the refusal to allow sterilization was based on purely medical considerations. Mrs. Chrisman contended that, actually, the hospital's committee on sterilization made a value choice involving moral and religious considerations. The minutes of the committee disclosed that, in each case when sterilization operations were not recommended, the patient desired the operation for socioeconomic rather than medical reasons. The court stated that "the meaning of these social and economic considerations involves a question of fact." At the time this report was written the trial was still pending.

As stated above, Oregon has a statute which requires every County Health Department and permits any County Welfare Department to offer "family planning and birth control services" to persons whose family income does not exceed \$6,000 (see *Laws Establishing Family Planning Programs*). The statute defines "family planning and birth control services" as including "referral to a licensed physician for consultation, examination, medical treatment and prescription." It is not clear whether voluntary sterilization is included. The CFPPD survey indicates that the state health agency refers low-income persons to the University of Oregon Medical School for free sterilizations and that local welfare agencies are authorized to refer eligible public assistance recipients for voluntary sterilization and required to pay for sterilization procedures for those who wish them. (See Policy section.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* Current state health agency policy on family planning consists of a "Resolution on Family Planning" of the Oregon State Board of Health (undated), a statement on "Availability of Services" (undated) issued by the Maternal and Child Health Section, and *Guidelines for Family Planning Clinics*, issued by the Family Planning Program of the Maternal and Child Health Section, July 1970. The current "Resolution on Family Planning" "encourages family planning services as an approved part of local health department activities" and authorizes the State Board of Health to provide assistance to other agencies in the development of family planning services using "such appropriate and approved funds as are available." A proposed updating of the "Resolution" reflects a change in Oregon law requiring every county health department to offer family planning services within

the limits of available funds (See Laws on Contraception, above). The statement on "Availability of Services" sets forth eligibility requirements and basic standards for family planning programs. The *Guidelines* set forth more detailed descriptions and guidance on local clinic responsibilities, the availability of family planning services, content of clinic services, types of contraceptive services, follow-up services, other ancillary services, clinic personnel requirements, use of volunteers, use of community public health aids, advisory committees, and appendices presenting approved record keeping forms for family planning clinics and other materials.

2. *Eligibility*:¹ The State Board of Health policy contained in "Availability of Services" (cited above) states that "family planning services will be available in Oregon . . . without regard to race, religion, nationality, maternity, marital status or age." With respect to financial eligibility, the State Board of Health indicated in the CFPPD survey that "the highest income level for eligibility for family planning clinic services would be an aggregate income of \$6,000 for a family."² In order to receive services from a given family planning facility, it is required that patients live in the "general geographic area of the clinic." No fees are charged in any clinic supported by the program.

3. *Administration*:³ The Maternal and Child Health Section, Office of Preventive Medical Services has administrative responsibility for family planning in the Oregon State Health Division, Department of Human Resources. The following staff are assigned to family planning activities: One Public Health Physician (Project Director), 10–25 percent time; one full-time public health educator; one full-time information representative; one executive assistant, 25–50 percent time; one secretary, less than 10 percent time; two public health nurses, less than 10 percent time; one public health educator, less than 10 percent time; and one nutrition consultant, 10–25 percent time.

The state health agency performs the following functions in support of family planning activities: consultation; training; development and distribution of public education materials; grants or contracts to local family planning programs for support of services; and production of television public service announcements for statewide distribution. The Oregon State Health Division uses the United States Public Health Service's National Center for Health Statistics unified reporting system; the family planning program provides consultation to local health departments for this system.

4. *Financing*:⁴ \$100,047 of new MCH funds were allocated to the state for FY 1971 which were federally earmarked for family planning. All of these funds

were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$434,508. An estimated \$282,430 were spent for family planning services. In FY 1971, the Oregon State Health Division received a \$29,880 appropriation for family planning from the state legislature. No other state funds were utilized by the state health agency for family planning.

5. *Voluntary Sterilization*: The Oregon State Health Division has no written policy in regard to voluntary sterilization; however, low income persons are referred to the University of Oregon Medical School for free sterilizations according to the CFPPD survey.

Footnotes:

1. Unless otherwise indicated, information contained in this section was reported by the state health agency in the CFPPD survey.
2. This is similar to federal standards for Crippled Children's Programs.
3. As reported in CFPPD survey.
4. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW). January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Oregon is contained in *Executive Bulletin 69-19*, dated March 21, 1969, of the Public Welfare Division. Revision No. 2, dated July 1971, to *Pharmaceutical Services, Guide for Public Welfare Medical Services* contains a list of approved drugs and devices for family planning and the payment levels for these items. *Executive Bulletin 69-19* states: "Medical services related to family planning are provided for persons eligible for medical care in the same manner as any other services included in agency medical programs." The *Bulletin* also states: "Public Welfare is required by law to 'initiate and conduct discussions of family planning with each welfare recipient who might have an interest in and benefit from such services'." The policy contains no statement on the objectives of family planning programs.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Oregon Public Welfare Division *authorizes* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. However, local welfare agencies are *required* to *purchase* family planning services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, voluntary agencies and private physicians. *Bulletin 69-19* states that "the agency makes no payment to county health departments providing family planning services, nor to any clinic

where no charge is made to the general public. Payment to the Planned Parenthood Association is limited to the first visit and one subsequent visit per year, except in emergencies; payment to the Association may include supplies prescribed during authorized visits only." The Division reported that there is a single, standard statewide reimbursement rate for medical family planning procedures.² The reimbursement rates are as follows: Initial medical examination, \$41.50 plus \$4.75 pap smear; Annual medical examination, \$14.50; IUD insertion, \$4.75 each (fee for service-office visit, cost of IUD, pap smear); one cycle of oral contraceptives, \$2.20.

The Welfare Division reported that both it and local welfare agencies have contracts and/or other formal arrangements with providers of services for the provision of family planning services. According to the Division, reimbursements for medical family planning services are made "by contract with Portland Planned Parenthood Association and the State Department of Health."

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are apparently eligible for referral services only. General Assistance recipients are eligible for medical family planning services.

There are no additional limitations that affect the provision of services to adults. Parental consent is required for the provision of services to all minors except those that are married or emancipated. The minimum age for the provision of services to all minors except those that are married or emancipated is 12. *Bulletin 69-19* provides that "in providing services to minors, every effort should be made to elicit the full cooperation of the parents, guardian or foster parents, since services are more likely to be effectively used if the family understands and accepts the need for them." Under Oregon law, however, "any physician may provide birth control informa-

tion and services to any person without regard to the age of such person and a minor, 15 years of age or older, may give consent to medical or surgical diagnosis or treatment by a licensed physician . . . without the consent of a parent or guardian" (See Law on Minors, above).

4. *Administration*:⁴ The Family and Children's Services Division, the Adult Services Section, and the Medical Assistance Section in the Oregon Public Welfare Division are responsible for the administration of the family planning program. No staff are assigned either full- or part-time to family planning. The main activity of the responsible agencies involves the training of local welfare staff.

5. *Financing*:⁵ The Public Welfare Division received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Public Welfare Division has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Division *authorizes* local welfare agencies to *refer* eligible public assistance recipients for voluntary sterilization procedures and also *requires* local agencies to *pay* for sterilization procedures for those who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Oregon Medicaid program, family planning services are "Provided. Under direction of physician; including drugs, supplies, and devices. . . . Reimbursement on basis of fee schedule." The 1970 City University of New York study reported that \$12,270 was expended for medical family planning services and \$39,668 for drugs and devices by the Oregon Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures were \$14,970 and \$48,395 respectively. (For additional information on Medicaid see Federal Laws and Policies section of this report.)
3. As reported in the CFPPD survey.
4. Ibid.
5. Ibid.

Pennsylvania

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Pennsylvania.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

Section 4659 of Pennsylvania's laws prohibits the sale of drugs or articles for the treatment or prevention of disease through vending machines. Pa. Stat. tit. 18, § 4659 (1945).¹

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Under Pennsylvania law it is a misdemeanor to advertise, or to sell or give away an account or description of "any secret drug, nostrum, medicine recipe or instrument" for the use of females for the purpose of preventing conception. An exception is made in the statute for teaching in regularly chartered medical colleges and the publication of standard medical books. Pa. Stat. tit. 18, § 4525 (1945).

In *Commonwealth v. Rupp*, 47 D & C 302 (Allegheny Co. 1941), it was held that the sale of condoms does not violate Section 4525, Pa. Stat. tit. 18 (1945) (See below). (The court said that even if § 4525 were not violated, their sale in mixed company or to a group of maturing children might constitute a common-law offense; however, it is not a common-law offense to sell condoms surreptitiously to a group of men in a tavern.)

In *Commonwealth v. Mosholder*, 46 D & C 31 (Cambria Co. 1942), the court construed Section 4525, as amended in 1939. (Before its amendment, the section prohibited the sale of contraceptives.) It was held that the possession or sale of contraceptives did not violate the statute provided they were not publicized or exhibited in any manner.

In *Commonwealth v. Payne*, 66 D & C 462 (Beaver Co. 1948), the court reaffirming the decision in *Mosholder*, held that the sale of contraceptives is no longer prohibited provided that articles are not publicized or exhibited. The court added dicta stating that it is prohibited to sell condoms through vending machines.

4. *Laws Relating to Contraceptive Services to Minors:* A minor is an individual younger than 21 years of age. Pa. Stat. tit. 46, § 601 (1969).

However, Pennsylvania has a comprehensive law adopted in 1970 governing the right of minors to consent to medical services. Pa. Stat. tit. 35, §§ 10101–10105 (1971 Cum. Supp.). Under this law, consent may be given by the minor, without parental consent, where the minor is 18 years of age or older or has been graduated from high school, or has married, or has been pregnant. § 10101.

Any minor who has been married or has borne a child may give effective consent to medical services for the child. § 10102.

Any minor "may give effective consent for medical and health services to determine the presence of or to treat pregnancy and venereal disease. . . ." § 10103. Pennsylvania also amended its Disease Prevention and Control Law in 1971, adding a provision that "[a]ny person under the age of 21 years infected with a venereal disease may be given appropriate treatment by a physician. If the minor consents to undergo treatment, approval or consent of his parents or persons in loco parentis shall not be necessary and the physician shall not be sued or held liable for properly administering appropriate treatment to the minor." Act No. 156, S. B. No. 528 (1971), adding Pa. Stat. tit. 35, § 521.14a.

Medical and health services may be rendered to minors of any age without the consent of parent or guardian when "in the physician's judgment, an attempt to secure consent would result in delay of treatment, which would increase the risk to the minor's life or health." Pa. Stat. tit. 35, § 10104 (1971 Cum. Supp.).

The consent of a minor "who professes to be, but is not a minor whose consent alone is effective to medical . . . and health services shall be deemed effective . . . if the physician or other person relied in good faith upon the representations of the minor." § 10105.

In *Zaman v. Schultz*, 19 Pa. D. & C. 309 (1933), the court recognized the "mature minor doctrine" allowing a minor to consent to a procedure which is for his or her benefit, if he is old enough and intelligent enough to understand the procedure; but the court refused to apply the doctrine because the medical procedure in that case (donation of blood by the minor to her employer) was not for the minor's benefit.

Two early Pennsylvania cases are frequently cited in discussion of the law governing neglected minors. In *Heinemann's Appeal*, 96 Pa. 112 (1880), it was held that a court properly appointed a guardian for two minor children whose father had neglected to provide medical treatment for his wife and three other children, all of whom died of diphtheria. In *re Tony Tuttendario*, 21 Pa. Dist. 561 (1911) involved a petition by an officer of a benevolent society alleging that a seven-year-old boy living with his parents suffered from rickets and required surgery which his parents refused to permit. The court dismissed the petition, which sought to have the boy committed to the society for the purpose of an operation, on the ground that a court should not interfere with parental judgment at least so long as the child's condition is not life threatening. However, in *In re Marsh*, 140 Pa. Super. 472, 14 A. 2d 368 (1940), the court affirmed an order committing a child to a welfare agency as a neglected child where the neglect consisted of failure to have the child vaccinated. The decision was based on the fact that the child could not attend school unless vaccinated.

Footnote:

1. The Beaver County Court in its dicta in *Commonwealth v. Payne*, 66 D & C 462 (Beaver Co. 1948), seems to extend the ban of Section 4659 (prohibiting the sale of drugs or articles for the prevention of disease through vending machines) to condoms sold in vending machines for contraception as well as "for the prevention of disease."

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Shaheen v. Knight, 11 D & C 2d 41 (Lycoming County Ct. 1957), decided by one of Pennsylvania's lower courts, was an action against a physician based on the failure of a voluntary sterilization operation which had resulted in the plaintiff's fathering a child. The theory of the action was the doctor's breach of a contract to make the plaintiff sterile. Damages were sought for the expenses of rearing the child born as a result of the operation's failure.

In upholding the contract, the court held that a contract to sterilize a man, for whatever reasons, "is not void as against public policy and morals." Nevertheless, the plaintiff was not permitted to recover on the ground that it would be inequitable for him to have the "fun, joy and affection . . . of rearing and educating" the child while the doctor supported it.

The CFPPD survey indicates that the Department of Public Welfare requires referral and payment for sterilization procedures by local welfare agencies for eligible welfare recipients who wish them (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: A statement adopted by the Pennsylvania Advisory Health Board, August 17, 1965, "recognizing the importance of family size to family health, . . . strongly supports the concept of 'family planning' as a method of protecting the health of the people of the Commonwealth." It states further that "the Department [of Health] recognizes its responsibilities to cooperate and coordinate its activities with those departments which have responsibility for providing services for the indigent and medically indigent who, without help, would be deprived of this health service."

A memorandum dated August 6, 1969, from the Acting Secretary of Health to supervisory personnel of the Department of Health stated that the Department would "assume responsibility for the educational aspects (including staff training) of family planning. . . ." At that time the Department did not participate in the provision of medical family planning services. In order to implement the 1969 policy, regional family planning committees were established to survey available family planning services and to carry out the educational program.

In response to several proposals made by the Secretary of Health in a July 17, 1970 letter, Governor Shafer approved the expenditure of federally earmarked MCH funds for family planning services and the establishment of a family planning unit, with additional staff, in the Division of Maternal and Child Health. The family planning unit issued *Guidelines and Instructions for Preparing and Submitting Service Contract Applications* in January 1971. These guidelines discuss departmental objectives, the purposes for which applications will be considered, funding priorities, eligibility for receipt of funds, matching requirements, contract duration, expenses which can and cannot be covered by state funds, and arrangements for infertility services. The *Guidelines* set forth detailed application procedures, medical and administrative standards for clinic operations, and sample application forms. The *Guidelines* state that contracts will cover generally a 12 month period (fiscal year). Funds may be used to pay salaries of clinic staff, to purchase contraceptive materials, to cover the cost of pap smears, and to cover staff, educational, travel and other direct operational costs. Funds may not be used for any surgical procedures, including abortions and sterilizations, for construction or rental of facilities, or to purchase or rent office equipment or furnishings.

2. *Eligibility*: According to the Department of Health's response to the CFPPD survey, the state health agency neither recommends nor establishes eligibility requirements or patient fees for family planning services. However, the guidelines cited

above indicate that "clinic services authorized and funded in the services contract are to be provided to patients free of charge." A routine clinic fee may be established to cover items not covered by the state project grant, but such fees must be justified to the health agency. The "funding priorities" set forth in the guidelines indicate that "priority in funding will be given to projects serving . . . low income families and population groups with excess fetal and infant mortality."

3. Administration: The family planning unit of the Division of Maternal and Child Health has administrative responsibility for family planning services in the Department of Health. Staff assigned to family planning activities at the state level include: the Director of Maternal and Child Health, 25-50 percent time; one nursing consultant, full-time; one program secretary, full-time; one administrative officer, 25-50 percent time; and one public health educator, full-time.

The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; purchase or provision of supplies, equipment or other materials to local family planning programs in state clinics; and grants or contracts to local family planning programs for support of services. A central data processing system is under development.

4. Financing:¹ \$419,405 were allocated to the state in FY 1971 which were federally earmarked for family planning. \$328,777 or 78.3 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$2,092,697. Approximately \$21,000 were spent for family planning services. The Department of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other funds were utilized by the state health agency for family planning.

5. Voluntary Sterilization: The Department of Health *Guidelines* cited above, state that Department of Health funds cannot be used for "any surgical procedures, including abortions and sterilizations. . . ."

Footnote:

1. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. Summary of Current Welfare Policy:¹ Welfare family planning policy in Pennsylvania is contained in

Supplement No. 3 to Memorandum No. 870, dated January 5, 1968, issued by the Department of Public Welfare, Paragraph 2 of the one-page *Memorandum* is as follows:

Information and referral services in respect to family planning are social services that the Department provides to public assistance applicants or recipients (or to former or potential applicants or recipients). The services are made available to clients either at the client's request for such help or initiated by the caseworker upon identification of a social or health problem that might be alleviated by the use of family planning services which are medical services.

Additional family planning policy is contained in Section 3.7 of the Title IV-A State Plan of Service Programs for Families and Children, dated May 1969. The policy contains no statement on the objectives of the family planning programs.

2. Referral and Purchase Provisions:² Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical family planning services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies and private physicians. The Department reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures. The reimbursement rates are as follows: Initial medical examination, \$10.00; Annual medical examination, \$10.00; IUD insertion, \$4.00 for office visit and cost to vendor for the cost listed in the Pharmacist Formulary Book.

Although there is no existing contract with providers of family planning services, the Department of Welfare is negotiating such a contract with one provider for the provision of family planning services.

3. Eligibility:³ All current recipients of federally-aided assistance as well as applicants, past recipients and potential recipients of such assistance, residents of low-income areas and General Assistance recipients are eligible for medical family planning services.

There are no additional limitations which specifically restrict the provision of services to adults or minors. According to Section 3.7 of the State Plan: "Family planning services will be available without regard to marital status, age or parenthood."

4. Administration:⁴ Responsibility for the administration of the family planning program rests with the Bureau of Family and Child Welfare in the Office of Family Services of the State Department of Public Welfare. The Director of the Bureau of Family and Child Welfare spends less than 10 percent of his or her time on family planning activities. Family

planning activities of the Bureau are confined to the development of a statewide family planning program.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *requires referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was

reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Pennsylvania Medicaid program, family planning services are "Provided. Physician's services provided for all; drugs, supplies, and devices provided for categorically needy persons only. Anovulatory drugs limited to 80-day supply per prescription. Prior authorization from local office required if prescription exceeds \$10., or from State office if cost exceeds \$50. Reimbursement on basis of fee schedule." The 1970 City University of New York study reported that \$39,699 was expended for medical family planning services and \$136,121 for drugs and devices by the Pennsylvania Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures were \$45,000 and \$155,000. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)

3. As reported in the CFPPD survey.

4. Ibid.

5. Ibid.

Rhode Island

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: There is no law establishing a state family planning program in Rhode Island.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: None found.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 21.

By statute, any person who is 16 or older or married¹ may consent to "routine emergency medical or usrgical care." A minor parent may consent to treatment of his child. R.I. Gen. Laws Ann. § 23-51-1 (Supp. 1971).

Minors of any age may give legal consent for examination and treatment for any venereal infection. Such examination and treatment by a registered physician upon the person of a minor who has given consent "shall not constitute an assault or an assault and battery." R.I. Gen. Laws Ann. § 23-11-11 (1968).

Although no cases were found regarding the right of emancipated minors to consent to their own medical care, Rhode Island courts have recognized the common law doctrine of emancipation. They have also recognized that there can be "partial emancipation". It is likely that they would follow the common law rule that an emancipated minor can consent to medical services and that a minor can be emancipated for the purpose of consenting to his or her own medical care.

In *Lottinville v. Dwyer*, 68 R.I. 263, 27 A. 2d 305 (1942), a father and mother and their 12-year-old daughter sued an estate for services allegedly rendered to the decedent. The defendant argued that the daughter could not sue for her own earnings. The court held that the jury could make a finding of "partial emancipation," stating;

A waiver or relinquishment of the parent's right to the earnings of the infant for a special purpose or in a particular instance, sometimes called partial emancipation, may occur although the infant continues to live with his parents. 27 A. 2d at p. 309.

An earlier case had held that, by confirming and approving an agreement between the plaintiff's

minor son and the defendant corporation whereby the son agreed to remain in the defendant's employment for three years, "the plaintiff in effect emancipated his son, so far as the wages earned under the contract were concerned, and gave the wages to his son. They became, therefore, the property of the son, and not the property of the plaintiff." *Pardey v. American Ship Windlass Co.*, 19 R.I. 461, 34 Atl. 737 (1896). See also *Genereux v. Sibley*, 18 R.I. 43, 25 Atl. 345 (1892).

No cases were found indicating whether Rhode Island courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

"Whenever a child who has been brought before the family court appears to be in need of medical or surgical care, the court may order the parent, guardian or other custodian to provide treatment for such child in a hospital or otherwise. If such parent, guardian or other custodian fails to provide such care, the court may, after due notice, enter an order therefor; and the expense thereof when approved by the court shall be charged to the state, if the parents are unable to pay the same." R.I. Gen. Laws Ann. § 14-1-51 (1970).

Footnote:

1. The age of consent to marriage is 18 for males and 16 for females, but younger minors can marry with the approval of the family court. All minors need parental consent in order to receive a marriage license. R.I. Gen. Laws Ann. § 15-2-11 (1970).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The CFPPD survey indicates that the Department of Social and Rehabilitative Services, with "[P]rior approval based on medical, hospital and social service evaluation, authorizes referral for sterilization procedures for eligible welfare recipients" who wish them (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: Rhode Island Department of Health policy on family planning

is contained in the state plan for Maternal and Child Health, Chapter 11, Maternal and Child Health, according to the Child Health unit.¹

2. *Eligibility:*² The Department of Health apparently recommends that there be no financial or geographical restrictions on eligibility and that there be no fees charged for services; however, third party payments are utilized where applicable. While not set forth in health agency policy, the following social criteria apply to eligibility: All categories of adults are eligible for family planning services; only married minors are eligible without parental consent.

3. *Administration:*³ The Division of Child Health has administrative responsibility for family planning services in the Department of Health. Staff assigned to family planning activities include: one medical consultant, 10–25 percent time; one family planning officer, 25–50 percent time; one child health administrator, 10–25 percent time; one nursing consultant, 25–50 percent time; and one clerical person, 25–50 percent time.

The Department performs the following functions in support of family planning activities; consultation, development and distribution of public educational materials, collection and tabulation of statistical reports from family planning clinics, and grants or contracts to local family planning program for support of services. A family planning advisory council meets monthly to advise the Director of Health on planning, development and coordination of all family planning activities.

4. *Financing:*⁴ \$15,461 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning; \$10,000 or 64.7 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$234,970. An estimated \$35,245 of these funds were spent for family planning services. The Department of Health received \$56,000 in appropriations for family planning from the state legislature in FY 1971. No other state funds were utilized by the state health agency for family planning services.

5. *Voluntary Sterilization:* The Department of Health has no written policy in regard to voluntary sterilization.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Rhode Island is contained in Chapter I, Section 100.2, page 21 of the *Rhode Island Public Assistance Service Manual*, dated December 1969. Additional family planning policy is contained in Section 27 of the *Family Manual*, dated October 1970, of the Department of Social and Rehabilitative Services. The first sentence of Section 100.2 states: "Family planning, in so far as it relates to methods of birth control, has by its very nature been complex and controversial through the ages." Section 27 of the *Family Manual* provides: "Clients receiving financial assistance, as all citizens, are individuals with the right and responsibility of free choice and self-determination. Family planning services, social, medical and educational, are offered and provided to those individuals wishing such service." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social and Rehabilitative Services *authorizes* local offices to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients. Section 100.2 provides that "payment for medical services provided by a licensed physician, and payment for drugs and supplies prescribed by a licensed physician and provided by a licensed pharmacist, will be made in accordance with the established fee schedule for physicians' office visits for Medical Assistance recipients, and the established cost plus schedule established [sic] for pharmacists."

The policy, however, authorizes reimbursement only to private physicians. Hospital outpatient clinics, health departments, and voluntary agencies are not authorized to receive reimbursement under the policy. The Department reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures.² The reimbursement rates are as follows: initial medical examination, \$10.00; annual medical examination, \$10.00; IUD insertion—\$10.00 plus cost of device; one cycle of oral contraceptives, \$1.50 plus professional fee \$1.80 (\$3.30).

The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance and applicants for such assistance, and General Assistance recipients are eligible for medical family planning services. Past recipients and potential recipients of assistance and residents of low-income areas are eligible for referral services only.

The Department reported that single adults without a child are not eligible for family planning serv-

Footnotes:

1. Information as reported by the state health agency in the CFPPD survey.

2. Ibid.

3. Ibid.

4. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

ices. Married adults with or without child are eligible as are unmarried adults with at least one child. Section 100.2 states: "When the recipient is a married person and/or parent and the social study indicates problems which seem compounded by the size of the family, the social worker will discuss this and offer service, as with any other problem." The Department reported that "minors would be eligible for family planning service only with parental consent, and upon medical recommendations."

4. *Administration*:⁴ The Family and Children's Services Section of the Division of Community Services in the Department of Social and Rehabilitative Services has administrative responsibility for the welfare family planning program. No staff person has yet been designated with specific responsibility for family planning activities. Family planning activities of the responsible section are confined to the distribution of pamphlets.

5. *Financing*:⁵ The Department of Social and Rehabilitative Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Social and Rehabilitative Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department with "prior approval based on medical, hospital and social service evaluation," authorized referral for sterilization procedures for eligible welfare recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Rhode Island Medicaid program, family planning services are "Provided. Including supplies, devices, and appliances. Prior written authorization by State office for items not covered by State drug formulary. Reimbursement to physicians on basis of Physicians' Fee Schedule." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies section of this report).
3. As reported in the CFPPD survey.
4. Ibid.
5. Ibid.

South Carolina

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in South Carolina.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* A minor is any person who has not attained his 21st birthday, 1959–60 Opinions of Attorney General 231 (Opin. No. 685, Aug. 5, 1960.)

Married minors, however, can give valid and legally effective consent to any lawful diagnostic therapeutic surgical or postmortem [sic] procedure." S.C. Code § 11–157 (1971 Cum. Supp.)

The common law rule that males can marry at 14 and females at 12 is still in force in South Carolina. *State v. Ward*, 204 S.C. 210, 28 S.E. 2d 785 (1944). A statute provides that no marriage license shall be issued when the female is younger than 14 or when the male is younger than 16. S.C. Code § 20–24 (1962). This statute has been held to be simply a directive to the official issuing the license; a marriage of persons below the statutory age of consent is valid if the parties have reached the common law age of consent. *State v. Ward*, *supra*.

The statute regulating the issuance of marriage licenses also provides that when a female applicant is between 14 and 18 and when a male applicant is between 16 and 18 and when the applicant resides with father or mother or other relative or guardian, no license shall be issued without the consent of the parent, other relative or guardian. § 20–24. There are special provisions for the issuance of marriage licenses where the female is pregnant or has borne a child. S.C. Code § 20–24.5 (Cum. Supp. 1971).

In the opinion of the Attorney General, parental consent must be obtained before an operation may be performed on an unmarried minor unless an emergency exists. However, any requirement of parental consent for treatment of minors for venereal disease has, in the Attorney General's opinion, been abrogated by the general statutes covering venereal disease. 1959–60 Opinions of Attorney General 231 (Opin. No. 685, Aug. 5, 1960).

The Attorney General has also stated that, in

certain circumstances of emergency requiring immediate decision, parental consent to surgery on a minor is not necessary. 1958–59 Opinions of Attorney General 224, 226. Moreover, in an emergency, it is the Attorney General's view that medical care for a minor can be ordered by the court over parental objection, whether based on religious scruple or otherwise. 1965–66 Opinions of Attorney General 273 (Opin. No. 2144, Sept. 2, 1966).

Although we have found no case on the question of an emancipated minor (other than a married minor) consenting to his or her own medical care, South Carolina courts do view complete emancipation as an extinguishment of parental rights and duties (see the opinion discussed below) and thus presumably would follow the general pattern of permitting an emancipated minor to consent to his or her own medical care without the necessity of parental consent.

The leading case covers several aspects of emancipation: "Emancipation during minority results not from any act of the child alone, but primarily from agreement of the parent, which may be either express or implied. It may be either partial or complete. If partial, it frees the child for only a part of the period of its minority, or from only a part of the parent's rights, or for some special purpose, such as the right to earn and spend its own wages. If complete, it completely severs the parental relationship so far as legal rights and liabilities are concerned. Whether or not a minor child has been emancipated depends upon the peculiar facts and circumstances of each case, and is, therefore, generally a question for the jury. Emancipation of a minor child is never presumed, and the burden of proof is upon him who alleges it." *Parker v. Parker*, 230 S.C. 28, 94 S.E. 2d 12 (1956).

The Attorney General has stated that, in South Carolina, emancipation may be effected when the parent fails to support the child, when the child marries, when the child attains majority and when the child goes into military service. 1963–64 Opinions of Attorney General 155 (Opin. No. 1583, Oct. 22, 1963.)

In *Parker v. Parker*, *supra*, testimony showing that an 18-year-old male earned \$40–50 a week, paid his father \$12 a week as board, owned his automobile, was a member of the National Guard, and listed his

father as a dependent in his income tax return was considered sufficient evidence of emancipation to take the issue to the jury.

We have found no cases indicating whether South Carolina courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

B. Laws Relating to Voluntary Sterilization

With regard to voluntary sterilization for reasons other than health, the Attorney General has stated:

Where adults are involved, and particularly when the full and understanding consent of *both* husband and wife are obtained, . . . operations of vasectomy or salpingectomy may be performed by a surgeon without fear of criminal or civil liability. 1958-59 Op. Atty. Gen. 224, 226.

In 1962, the Attorney General was asked by a hospital about the conditions under which sterilization may be performed. At that time the Attorney General expressed the opinion that a sterilization operation on a male where the operation is deemed necessary from a medical standpoint to safeguard the life and health of the male or his spouse does not contravene the public policy of the state. The hospital was advised to obtain the written consent of the man to be sterilized and the written consent of his spouse. Letter from Assistant Attorney General Victor S. Evans to Mr. George I. Rentz, Administrator, Loris Community Hospital, November 19, 1962.

More recently, the Attorney General was asked about the legality of tubal ligation for indigent mothers. Citing the statute quoted below (§ 32-679), he replied:

While there is no decided law in this State, it appears to me that voluntary sterilization may be accomplished for therapeutic reasons. Whether it could be accomplished validly with the consent of the individual for social or economic reasons is a question which would require exhaustive research, and even then, might not be susceptible of a definite and clear-cut answer. I am inclined to think that it could probably be accomplished and statutory authorization validly made to cover the cost of the operation. Letter from Attorney General Daniel R. McLeod to E. A. Woodworth, M.D., April 7, 1966.

The opinions discussed above indicate that voluntary sterilization is legal in South Carolina and that, in the opinion of the Attorney General, there may be a requirement of spousal consent.

South Carolina also has a statute which provides for the compulsory sterilization of inmates of state institutions who are afflicted with certain incurable conditions. This statute contains the following provision:

Nothing in this article shall be construed to authorize the operation of castration nor the removal of sound organs from the body. But this provision shall not be construed as to prevent the medical or surgical treatment for

sound therapeutic reasons of any person in this State by a physician or surgeon licensed by this State in such a way as may incidentally involve the nullification or destruction of the reproductive functions. S.C. Code Ann. § 32-679 (1962).

In other words, if an operation such as a hysterectomy is performed for medical reasons on a person who is otherwise subject to the provisions of the compulsory sterilization law, the procedures prescribed in that law need not be followed although the operation may involve the removal of sound organs from the body.

Both Health and Welfare funds are available for voluntary sterilization (See Welfare and Health Policy, below).

Minors: In the earliest of the Attorney General's opinions discussed above, the following view was expressed with regard to the sterilization of minors:

Although there are circumstances in which sexual sterilization of minors meets with no technical legal obstacle, such as when full and understanding consent is obtained from the patient, spouse, and parents, when the health or life of the patient is involved, or in an immediate emergency involving the health or life of the patient, the greatest caution should be exercised in such cases by the surgeon. It would probably be advisable for a surgeon to limit his activity in this field, when dealing with minors, to cases in which the health or life of the patient is involved. 1958-59 Op. Atty. Gen. 224, 226.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current state health agency policy on family planning consists of a policy statement, *Recommendations and Policies for Family Planning Clinics*, promulgated by the State Board of Health in December 1970. The policy briefly discusses family planning information and counseling activities, medical standards, procedures for return visits, records, follow-up, clinic operations and staffing, and policies on eligibility. Supplementing the policy statement is a memorandum from the Bureau of Maternal and Child Health, dated January 1970, entitled *Suggested Definitions for Use in Family Planning Programs*.

2. *Eligibility:* In the *Recommendations* cited above, the State Board of Health recommends that: "services should be available to anyone desiring and needing them," "means tests" not be used; services be made available to both men and women; services be made available to "unwed, underage patients." In the CFPPD survey the Board indicated that although it recommends "that no charge be made, . . . a small number of Country Health Departments still request a donation [from patients]." With respect to minors, the Board indicated in the CFPPD survey that under current state law, minors are eligible for services, but all unmarried minors must have par-

ental consent. The Board also indicated in the survey that services to minors are "handled differently in different health departments throughout the state." Geographical eligibility requirements are determined locally.

3. *Administration*:¹ The Family Health Section, Bureau of Maternal and Child Care, has administrative responsibility for family planning services in the State Board of Health. Staff assigned to family planning activities include: one family planning coordinator, full-time; one health educator, full-time; one nursing consultant, 10–25 percent time; one social work consultant, 10–25 percent time; one medical director, 10–25 percent time; one volunteer consultant, less than 10 percent time; five program nurse specialists, 10–25 percent time.

The state health agency performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; development of grant applications for additional federal funding; evaluation; some direct services to patients.

4. *Financing*:² \$195,728 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. Approximately \$185,940 or 90 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$931,904. An estimated \$196,282 of these funds were spent for family planning services. The Board of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the state health agency for family planning services.

5. *Voluntary Sterilization*: State Board of Health policy on voluntary sterilization consists of a memorandum from the Bureau of Maternal and Child Health to all Health Officers and Maternal and Child Care staff, dated March 5, 1971. The memorandum announces that funds are available for voluntary sterilization services. The memorandum specifies maximum allowable payment for male and female sterilizations and includes forms for sterilization services. Eligibility for voluntary sterilization is "based on each individual case," according to the MCH unit.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in South Carolina is contained in Section 3.7 of the Title IV–A State Plan of Services Programs for Families and Children, dated May, 1969. Subsection (a) of section 3.7 of the State Plan states: "Family planning services, social, medical and educational will be offered and provided to those individuals wishing such services." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *recommends* that local welfare agencies *refer* eligible public assistance recipients to medical family planning services and also *recommends* that local welfare agencies *purchase* medical family planning services for these recipients. However, the Department indicated that purchase of services is recommended for public assistance recipients only "When recommended as medically needy by physician."

The policy authorizes reimbursements to hospital outpatient clinics and private physicians. Health departments and voluntary agencies are not authorized to receive reimbursement under the policy.² The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services. The Department, however, reported that it is "currently in process of planning projects under Title IV–A with State Board of Health."

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as General Assistance recipients are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only.

There are no additional limitations that affect the provision of services to adults. Section 3.7 states that "Family planning services will be available to those desiring it without regard to marital status, age or parenthood." The Department, however, reported that parental consent is required for the provision of services to *all* minors including those that are married or emancipated.

4. *Administration*:⁴ The Children and Family Services Division has responsibility for the administration of the welfare family planning program. Six consultants devote from 10 to 25 percent of their time to family planning activities and two Staff Developers spend less than 10 percent of their time on family planning. Family planning activities of the Division include the training of local welfare staff and the development and distribution of educational materials.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Serilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local welfare agencies. When sterilization procedures are "prescribed by the physician for Public Assistance recipients," the Department recommends that local welfare agencies pay for such services.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the South Carolina Medicaid program, family planning services are "Not provided." However, this publication is based on data as of January 1970 and the South Carolina Medicaid program may have been modified since that date. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in the CFPPD survey.
4. Ibid.
5. Ibid.

South Dakota

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in South Dakota.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* South Dakota has no state law specifically restricting the sale or distribution of contraceptive drugs or appliances other than a section which prohibits the manufacture, purchase, rental or possession of vending machines designed for prophylactics. S.D. Comp. Laws Ann. § 22-24-8 (1967). A "prophylactic" is defined as "any article or device of whatsoever nature intended or having special utility for preventing pregnancy or venereal disease." S.D. Comp. Laws Ann. § 22-24-9 (1967).¹ There are no cases or Attorney General opinions amplifying this definition; and it is unclear whether "article or device" refers only to condoms, or would also include other contraceptives such as pills and foams (often categorized as "drugs" or "medicines").

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Under South Dakota law, it is a misdemeanor to advertise or display "prophylactics." S.D. Comp. Laws Ann. § 22-24-7 (1967). ("Prophylactics" are defined as in 2, above.)

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 18. S.D. Comp. Laws Ann. § 26-1-1 (Supp. 1972). Age is "calculated from the first minute of the day on which persons are born, to the same minute of the corresponding day completing the period of majority." *Ibid.*

By statute, the authority of a parent ceases: (1) upon the appointment by a court of a guardian of the person of the child; (2) upon the marriage of the child; (3) upon the child attaining majority; (4) upon the emancipation of the child. S.D. Comp. Laws Ann. § 25-5-17 (1967).

The statute defines emancipation. "Emancipation is express when it is by agreement of both parents if living, and if not, the surviving parent and the child. Emancipation is implied when there has been complete abandonment of parental responsibility and control, and the child is actually obtaining support by other means or from other sources than his parent or parents." S.D. Comp. Laws Ann. § 25-5-19

(1967). "No child can be emancipated unless he is in no manner dependent on his parents for support." § 25-5-18. "Emancipation may be revoked by an agreement between the parents or parent and child, or by a resumption of family relations inconsistent with emancipation." § 25-5-22.²

Although no cases were found dealing with a minor's right to consent to his or her own medical services, presumably when, by statute, "the authority of a parent ceases," the minor can effectively consent (except in the case where a guardian is appointed, in which case the guardian's consent might be required).

Thus a married minor probably could consent to his or her own medical care. Males at 18 and females at 16 may marry. S.D. Comp. Laws Ann. § 25-1-9 (1967). Pregnant females may marry at any age with parental consent. § 25-1-12. No marriage license shall be granted to a minor without the written consent of the parent or guardian. § 25-1-13. This statutory requirement of parental consent has been held to be simply a directive to the official issuing the license, and lack of parental consent is not grounds for annulment. *Lessert v. Lessert*, 64 S.D. 3, 263 N.W. 559 (1935). The marriage of a party under the statutory age of consent may, however, be annulled. § 25-3-4.

Presumably a minor who is emancipated as defined in § 25-5-19 could also consent to his or her own medical care. This view is supported by the statute which provides that parental authority ceases upon emancipation of the child, as well as by a South Dakota judicial opinion describing emancipation as the "destruction of parental and filial relations." *Kloppenburger v. Kloppenburger*, 66 S.D. 167, 280 N.W. 062 (1938).

Licensed physicians may diagnose and treat minors of any age for venereal disease with the consent of the minor, who is granted the right of giving such consent. Treatment includes "prophylactic treatment for exposure to venereal disease whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease." S.D. Comp. Laws Ann. § 34-23-16 (Supp. 1971). "Treatment of a minor for venereal disease by a county health department, state health department or doctors attached to such departments shall be offered to a minor, if available, upon the minor's request and

without the necessity of consent of parents or notification to the parents." § 34-23-17. The physician who examines or treats a minor under these provisions "shall incur no civil or criminal liability" except for negligence. § 34-23-18.

We found no cases indicating whether South Dakota courts follow the general pattern of permitting medical treatment of minors without parental consent in emergencies or whether South Dakota courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

The statute dealing with neglected children includes in its definition of "neglected or dependent child" one "whose parent, guardian or custodian fails or refuses to provide proper or necessary subsistence, education, medical care or any other care necessary for his health, guidance, or well-being... Provided however...no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to have been neglected..." S.D. Comp. Laws Ann. § 26-8-6 (Supp. 1972).

The juvenile court may issue temporary orders providing for medical or surgical treatment as it deems in the best interest of any child under its jurisdiction prior to adjudication or disposition of his case. § 26-8-43.

"After making a reasonable effort to obtain the consent of the parent, guardian, or other custodian, the court may authorize or consent to medical, surgical or dental treatment or care for a child placed in detention or shelter care. When the court finds that emergency medical, surgical or dental treatment is required for a child placed in detention or shelter care, it may authorize such treatment or care, if the parents or guardian are not immediately available. The court may make such orders as may be necessary to secure the payment of the expense of treatment therein, either by the persons liable for the care and support of the child or by the county or both." § 26-8-43.

South Dakota also has a statutory proceeding whereby an abused child "may be freed from the dominion of the parent and the duty of support and education enforced." § 25-5-16.

The welfare department does not require parental consent for the provision of family planning services to any person under 18 who receives an assistance grant in his or her own right rather than as a dependent of a grantee. See "Welfare Policy," "Eligibility," below.

Footnotes:

1. A 1948 Attorney General opinion stated that persons operating vending machines selling contraceptives were subject to prosecution under (what is currently) Section

22-24-6, making it a misdemeanor to do any "act which openly outrages public decency and is injurious to the public morals." Op. Atty. Gen. 1947-48, p. 370. Prior to 1949, vending machines selling contraceptives were considered illegal under § 22-24-6. After 1949, when § 22-24-8 was enacted, persons operating vending machines selling contraceptives were violating § 22-24-8.

2. South Dakota also has a statute which provides that "[t]he parent, whether solvent or insolvent, may relinquish to the child the right of controlling him and receiving his earnings. Abandonment by the parent is presumptive evidence of such relinquishment." S.D. Comp. Laws Ann. § 25-5-12 (1967).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

The CFPPD survey indicates that the Department of Public Welfare recommends referral for sterilization procedures by local agencies of eligible welfare recipients who wish them. (See Welfare Policy, Sterilization, below.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The State Department of Health has no official written policy on family planning; however, "unofficial" written policy is provided in a letter from the Director of the Division of Public Health Nursing to the Region VIII Program Management Officer, National Center for Family Planning Services, DHEW, dated December 16, 1970. This letter discusses eligibility for family planning services and patient fees, and states that family planning clinical services are financed and staffed by the South Dakota State Department of Health in two locations.

2. *Eligibility:* Social eligibility criteria are recommended by the Department of Health, but are determined by local health agencies, according to the CFPPD survey. It is recommended that all adults be considered eligible for family planning services, and that minors be considered eligible except that unmarried minors must have parental or guardian consent. "Unmarried minors must have written permission of parents or legal guardians and have this signed by a competent witness, and dated, for examinations and dispensing of contraceptives," according to the letter cited above. Financial eligibility requirements are determined by local health agencies according to the CFPPD survey. No fees are charged in health agency clinics according to the letter cited above. No reference is made to geographical eligibility criteria.

3. *Administration:*¹ The Special Services Division has administrative responsibility for family planning services in the Department of Health. Staff assigned

to family planning activities include: one family planning coordinator, full-time; one public health nurse, full-time; one public nurse, 25-50 percent time; and 40 locally assigned public health nurses, less than 10 percent time.

The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing*:² The Department of Health received \$14,715 of new MCH funds for FY 1971 which were federally earmarked for family planning. None of these funds were obligated for family planning. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$208,877. An estimated \$30,000 of these funds were spent for family planning services. The state health agency received no specific legislative appropriation for family planning services in FY 1971. No other state funds were utilized by the state health agency for family planning services.

5. *Voluntary Sterilization*: The Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in South Dakota is contained in Chapter 10-C of the *Manual of the State Department of Public Welfare*, dated November 1968. According to Chapter 10-C of the *Manual*: "The objective of family planning service is to improve the health of the people, to strengthen the integrity of the family and to provide families freedom of choice to determine the spacing of their children and the size of their families. Family planning services are also intended to prevent or reduce the incidence of births out-of-wedlock." Chapter 10-C states: "Priorities for family planning services offered by the State Department are as follows: 1. women who are currently pregnant out-of-wedlock; 2. mothers who have had a child born out-of-wedlock within the two preceding years; 3. youths living in conditions immediately conducive to births out-of-wedlock; or 4. others."

A section of the *Manual* on initiating the discussion of family planning provides that "the worker should keep in mind that it is often easier to approach the subject if it is done in the context of total planning with the family and is, therefore, related to something else of concern to the client."

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *recommends* that local welfare agencies *refer* eligible public assistance recipients to medical family planning services. Chapter 10-C states that family planning services offered and provided through the State Department include "enabling services, including medical contraceptives and other medical services (diagnosis, treatment, supplies, drugs and follow-up), child care services, and transportation as required." The policy authorizes reimbursements to hospital outpatient clinics, private physicians, and "family planning centers." Health departments and voluntary agencies are not authorized to receive reimbursement under the policy. There is no single, standard, statewide reimbursement rate for family planning procedures.² The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. Chapter 10-C provides that:

Responsibility for payment of enabling services recognized by the State Department is limited to individuals receiving financial assistance or individuals living in the same household whose financial needs are taken into account in making the determination of eligibility for assistance or other individuals who are eligible to receive financial assistance from this agency.

The Department does not fund or administer a General Assistance program.

There are no additional limitations that affect the provision of services to adults. According to Chapter 10-C, parental consent is required for the provision of services to all persons under 18 except "where the person who is under 18 receives a grant in his or her own right."

4. *Administration*:⁴ The Medical Administration and the Service Administration in the State Department of Public Welfare share responsibility of the administration of the welfare family planning program. No staff are assigned either full- or part-time to family planning. Family planning activities of these agencies include the training of local welfare staff and the development and distribution of public educational materials.

5. *Financing*:⁵ There is a specific state appropriation for family planning services in the South Dakota Department of Public Welfare. In fiscal year 1971 there was an appropriation of \$40,000 to the Department of Public Welfare.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department recommends referral for sterilization procedures by local agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was

- reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the South Dakota Medicaid program, family planning services are "Provided. Drugs, supplies, and devices when such services are under the supervision of a physician. Reimbursement on basis of usual and customary charges for such items prescribed." The 1970 City University of New York study reported projected expenditures of \$2,651 for medical services and \$636 for drugs and devices under the South Dakota Medicaid program in fiscal year 1970. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in the CFPPD survey.
4. Ibid.
5. Ibid.

Tennessee

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* In 1971 the Tennessee legislature enacted the Family Planning Act of 1971, establishing the policy of the state on the subject of contraception. Senate Bill No. 871, Ch. No. 400, Public Acts of 1971. The Act specifies that "all medically acceptable contraceptive procedures, supplies and information shall be readily and practicably available" to all persons desiring them "regardless of sex, race, age, income, number of children, marital status, citizenship or motive." Contraceptive procedures, including sterilization, are declared to be consistent with public policy,¹ as is dissemination of contraceptive information by authorized persons at schools, in state and county health and welfare departments, in medical facilities at institutions of higher learning, and at other agencies and instrumentalities of the state. A physician may refuse to furnish contraceptive supplies or information for medical reasons. Physicians and private institutions and their employees may also refuse to provide such information and supplies for reasons of religion or conscientious objection.

To the extent that family planning funds are available, the statute directs each public health agency of the State and its political subdivisions to provide contraceptive procedures, supplies and information to persons eligible for free medical services. The same service shall be available to others who cannot obtain it privately at a cost to be determined by rules and regulations promulgated by the Commissioner of Public Health.

The Department of Public Health is authorized to receive and disburse funds that may become available to it for family planning programs to any public or private organization engaged in providing contraceptive procedures, supplies, and information. Any family planning program administered by the Department of Public Health "may be developed in consultation and coordination with other family planning agencies in this state, including but not limited to Planned Parenthood Affiliates."

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found (See footnote 1.)

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Re-*

specting Contraceptives: None found.

4. *Laws Relating to Contraceptive Services to Minors:* In May, 1971, Governor Winfield Dunn signed a new law giving 18-year-olds "the same rights, duties and responsibilities as a person who is 21 years of age or older." Tenn. Code Ann. § 1-313 (Cum. Supp. 1971). Tennessee has a procedure whereby a court may remove the disabilities of minority of any minor who is at least 16 years of age and married. Tenn. Code Ann. §§ 23-1201-23-1204 (Cum. Supp. 1971).

Under the Family Planning Act of 1971, "contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such service by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of [the state of Tennessee] or any subdivision thereof, or who requests and is in need of birth control procedures, supplies or information." Tenn. Code Ann. § 53-4607 (Cum. Supp. 1971).

The Tennessee Attorney General has stated that, under this Act, "physicians, both those in private offices and those in local health departments, may provide contraceptive procedures and supplies (excluding surgical sterilization) to minors without the consent of their parents." Letter from Lance D. Evans, Assistant Attorney General to Thurman T. McLean, Jr., Staff Attorney, Department of Public Health, July 23, 1971.

In addition, Tennessee has a statute authorizing any physician or health officer to examine, diagnose and treat minors infected with venereal disease without the knowledge or consent of the parents of the minors. The statute provides that physicians and health officers so doing shall incur no civil or criminal liability except for negligence. Tenn. Code Ann. § 53-1104 (Cum. Supp. 1971.)

Footnote:

1. This declaration of policy may be considered inconsistent with the court's reasoning in a 1937 case upholding the power of the City of Knoxville to pass an ordinance prohibiting the sale of contraceptive goods except by licensed physicians and pharmacists. *McConnell v. Knoxville*, 172 Tenn. 190, 110 S.W. 2d 478 (1937). The court there held that the indiscriminate sale of contraceptives by peddlers and in vending machines at stores and filling stations was

a menace to the morals and health of the people, and that, therefore, a municipal ordinance regulating the subject matter was constitutional.

B. Laws Relating to Voluntary Sterilization

The Family Planning Act of 1971, discussed above under Laws Establishing Family Planning Programs, provides that "contraceptive procedures, including medical procedures for permanent sterilization, when performed by a physician on a requesting and consenting patient, are consistent with public policy." When so requested in writing by any person 18 years of age or over, or less than 18 if legally married, a licensed physician or surgeon may perform "a surgical interruption of the vas deferens or fallopian tubes." Prior to or at the time of the request for the operation, the physician or surgeon must give the patient "a full and reasonable medical explanation as to the meaning and consequences of such operation." The Act provides that all contraceptive procedures shall be readily and practicably available to all persons desiring them.

The physician or surgeon is freed by the statute from civil or criminal liability for having performed the surgical interruption of the vas deferens or fallopian tubes, except for negligence. He may refuse to perform the operation for medical reasons, or conscientious objection.

The statute further provides that no contract of insurance covering sterilization procedures may be entered into or renewed on or after July 1, 1971, if such contract imposes any disclaimer, restriction on, or limitation of coverage with respect to the insured's reason for sterilization. (See Laws Establishing Family Planning Programs, above, for fuller discussion of this statute.)

The CFPPD survey indicates that health department policy encompasses referral for and purchase or provision of voluntary sterilization services for men and women who wish them and that welfare department policy requires referral for sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Minors: The above statute specifically authorizes surgical interruption of the vas deferens or fallopian tubes upon request of any person 18 years of age or over, or less than 18 years of age if married. The Attorney General has expressed the opinion that unmarried persons under 18 cannot consent to surgical sterilization. (See Laws Relating to Contraceptive Services to Minors, above.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current Department of Public Health policy on family planning consists of *Rules and Regulations of the Family Planning Act of 1971* transmitted in a *Special*

Letter to all local health departments by the Commissioner of Public Health on September 14, 1971. The promulgation of these *Rules and Regulations* is a direct result of the passage of the Family Planning Act of 1971 which became effective May 25, 1971 (See Laws Establishing Family Planning Programs, above.) The new regulations declared that it is the legal responsibility of the Commissioner of Public Health to implement the Family Planning Act of 1971; they establish eligibility requirements for contraceptive services and sterilization; they set policies on patient fees; they describe procedures for medical services to new and continuing patients using various contraceptive methods; they prescribe standards for medical supervision of clinical services; and they describe procedures for referral from the Department of Public Welfare.

2. *Eligibility:* The Department of Public Health reported in the CFPPD survey that it recommends financial, social and geographical eligibility criteria which correspond to those established by the 1971 statute. Under the recommended policy all "residents of the state" are considered eligible for family planning services. No parental consent or minimum age requirements are established for minors. No fees may be charged for services. According to the *Rules and Regulations* cited above, "where any previous state or local policies are in conflict the following policies, rules and regulations shall take precedence. . . . In the event that these rules and regulations are not maintained to meet minimum standards, funding . . . of health care services may be jeopardized in accordance with those existing policies in the Tennessee Code Annotated." The Department also indicated in the CFPPD survey, however, that "local health departments may still keep their own rules . . . while complying on paper to official policy."

The Family Planning Act of 1971 states with respect to eligibility for family planning services that "all medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship or motive." While the *Rules and Regulations* issued by the Department of Health quote this passage from the statute, one phrase in the *Special Letter* covering these regulations appears more limiting: "Contraceptive supplies and information may be furnished to any minor who requests it when directed by a physician (including public health physicians)." Although this is, as alleged, a specific directive in the law, when compared to the full statute, the *Rules and Regulations* on eligibility for family planning appear to be more limiting than the law allows.

3. *Administration:*¹ The Family Planning and Maternal Health Unit, Division of Family Health Serv-

ices, has administrative responsibility for family planning services in the Department of Public Health. State level staff assigned to family planning activities include the following full-time personnel: the Family Planning and Maternal Health Director, the Administrator, the Nurse Coordinator, two program representatives, and three clerical, statistical and secretarial staff members.

The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and program evaluation.

4. *Financing*:² \$215,866 of new MCH funds for FY 1971 were allocated to the state which were federally earmarked for family planning; the total allocation to the state of nonearmarked MCH funds for FY 1971 was \$998,326. No estimates are available for expenditures of MCH funds from these allocations.

The Department of Public Health received a \$400,000 appropriation for family planning from the state legislature in FY 1971.

No other state funds were utilized by the state health agency for family planning services in FY 1971.

5. *Voluntary Sterilization*: The current state health policy on voluntary sterilization is contained in the *Rules and Regulations* for family planning cited above. The *Rules and Regulations* quote the 1971 statute: "Contraceptive procedures, including medical procedures for permanent sterilization, when performed by a physician on a requesting and consenting patient, are consistent with public policy." No other mention of voluntary sterilization services is made in the *Rules and Regulations*.

According to the CFPPD survey, the policy encompasses *referral* for and *purchase* or provision of voluntary sterilization services for men and women who wish them.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Tennessee is contained in

Chapter XII of Volume IV in the *Tennessee Public Welfare Manual*, dated February 1969. Additional policy statements are contained in *Bulletin 72*, dated February 1969, under which Chapter XII was distributed. In Chapter XII of the *Manual* the Department of Public Welfare indicates that family planning services are a means of "helping people achieve stability" and of "restoring them to a condition of self-support." Chapter XII states that "in counties where there are no Family Planning Clinics, staff will explore the possibility of securing these services through other local health agencies and resources or Family Planning Clinics in adjoining counties."

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. However, Chapter XII states that "The Department of Public Welfare will not pay for medical examination and/or supplies used in family planning." The Department reported that it "uses the family planning clinics which have been established within the Department of Public Health. These clinics provide a full range of medical services in family planning. Title XIX, Medicaid (operated by the Department of Health) pays for these services for eligible persons (recipients of AFDC, AB, and AD [Aid to Families With Dependent Children, Aid to the Blind, and Aid to the Disabled])."² There is no single, standard, statewide reimbursement rate for medical family planning procedures. According to Chapter XII: "In order to insure maximum cooperation between the two agencies, the county welfare office must enter into a written agreement with the local health department." *Bulletin No. 72* provides: "When a county office finds that the local health department will not accept their referrals for the Family Planning Clinic, this information should be sent immediately to the Services to Children and Their Families Section." However, the Department reported that neither the local agencies nor the Department have contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as applicants, past recipients and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. The Department does not fund or administer a General Assistance program.

Chapter XII provides that "In offering family planning services to families, the husband should participate in making the decision to accept or reject these services." There are no other limitations that affect the provision of services to adults. As stated in the *Manual*, parental consent is required for the provision of services to minors except those that are

married or emancipated. Chapter XII provides: "When the minor accepts family planning services, her parent(s) or guardian(s) must give their consent in writing for her participation." In 1971, however, Tennessee enacted a law which provides that contraceptive supplies and information may be furnished by physicians to any minor "who requests and is in need of birth control procedures, supplies or information" (See Laws on Minors, above). The Welfare Department reported that its "policy will be revised," and further stated: "Parental consent is not required in family planning clinics. Clinics will serve the minor approximately one year after puberty."

4. *Administration*:⁴ The Division of Social Services in the Department of Public Welfare is responsible for the administration of the welfare family planning program. One Program Specialist, Family Planning Services, devotes full-time to family planning and services to unmarried persons. Family planning activities of the Division include the training of local welfare staff, the development and distribution of public educational materials, program development, and administrative review of services.

5. *Financing*:⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department *requires referral* for sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Tennessee Medicaid program, family planning services are "Provided. Legend drugs only. (Other services available through clinics of Department of Health.)" (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey, unless otherwise stated.
4. Ibid.
5. Ibid.

Texas

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Texas.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Texas has a statute which makes it unlawful to practice medicine without registering in the proper place and with the proper required information. Tex. Pen. Code Ann. art. 739 (1961). Article 740 makes this applicable "to persons other than registered pharmacists . . . not pretending to be physicians who offer for sale on the streets or other public places" contraceptives or prophylactics.¹ Other than this, we have found no state law restricting or regulating the sale or distribution of contraceptive drugs or appliances.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* Minors are "all persons under twenty-one years of age who have never been married, except persons under that age whose disabilities of minority have been removed generally, except as to the right to vote." Tex. Prob. Code § 3 (t) (1956). Except as expressly provided by statute or by the state Constitution, every person married in accordance with Texas law, regardless of age, has the rights of an adult, including the right to contract. Tex. Fam. Code § 4.03 (1971).

Texas has a statute entitled "Consent for child to receive medical care." Tex. Rev. Civ. Stat. art. 4447h (Cum. Supp. 1971). The statute provides that if any person younger than 21 years of age is in need of medical care for which parental consent is a necessary prerequisite, but neither of the parents can be contacted to give consent to administer the medical care, any of the following persons may give consent (in the absence of actual notice to the contrary by one or both parents): any grandparent; an adult brother or sister; an adult aunt or uncle; the legal guardian; or any other person who has custody of the child who has an affidavit signed by one or both parents authorizing the person to give consent. The statute further provides that the consent must be in writing and must include: the name of the minor child and the name of one or both parents; the name of the person giving consent and that person's rela-

tionship to the minor child; the name of the doctor, hospital or other medical facility rendering the medical care; a statement of the nature of the medical care to be rendered; and the date on which the medical care is rendered.

Texas also has a statute providing that any person, regardless of age, has the capacity to consent to examination and treatment by a licensed physician for any venereal disease. Tex. Rev. Civ. Stat. art. 4445b (Cum. Supp. 1971).

A Texas court has stated that a physician may treat a child without parental consent where there is an emergency "in the sense that death would likely result immediately" from failure to do so. See *Moss v. Rishworth*, 222 S.W. 225 at 226-7 (Comm'n of App. 1920).

We have found no cases indicating whether Texas courts follow the general pattern of permitting medical treatment without parental consent for emancipated minors (other than married minors, who have all the rights of adults, as stated above) or whether Texas courts would accept the "mature minor rule" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors." A Texas court has recognized, however, that a 15-year-old boy who "had been turned loose by his mother, his only surviving parent, to make his own living" was emancipated for the purpose of recovering damages for the value of his loss of time and earnings resulting from personal injury. *Gulf Cooperage Co. v. Abernathy*, 54 Tex. Civ. App. 137, 116 S.W. 869 (1909).

A Texas court has stated: "Medicines, medical treatment and attention are in a like category with food, clothing, lodging and education as necessities from parent to child . . . and proof that the parent is failing to provide any of these legal necessities to minor constituents of the family would, in our opinion, sustain a charge of parental neglect." *Mitchell v. Davis*, 205 S.W. 2d 812 (1947).

Welfare department policy provides that family planning services be made available "without regard to marital status, age or parenthood," and does not specify any requirement for parental consent (See "Welfare Policy," "Eligibility," below).

Footnote:

1. Parallel civil provisions are in Tex. Rev. Civ. Stat. Ann. arts. 4498 and 4504 (1966).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Frazier v. Levi, 440 S.W. 2d 393 (Tex. Civ. App. 1969), involved an attempt by the natural mother and guardian of a 34-year-old mentally incompetent woman to obtain a court order authorizing an operation sterilizing the patient for "socio-economic" reasons. The Court of Civil Appeals held that the application had been correctly rejected since the court lacked statutory or constitutional authority to order such an operation upon one unable to consent.¹

The CFPPD survey indicates that the Department of Public Welfare leaves the question of referral for voluntary sterilization procedures to the option of local agencies; local agencies are authorized to pay for sterilization procedures provided to eligible public assistance recipients who wish them (See Welfare Policy, Sterilization, below).

Footnote:

1. For cases holding both ways on this issue, see Ohio State Profile (Laws Relating to Voluntary Sterilization).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The Texas State Department of Health has no official written policy on family planning services.

2. *Eligibility*:¹ Social and geographical eligibility requirements for family planning services are established by the State Department of Health. Eligibility is established without regard to income limitations. All categories of adults are eligible for family planning services; minors are eligible for services, except that unmarried minors must have parental or guardian consent. "Under state restrictions [the State Department of Health] cannot knowingly serve Mexican nationals"; however, no other geographical requirements are imposed. There are no patient fees recommended or established by the Department.

3. *Administration*:² The Division of Maternal and Child Health has administrative responsibility for family planning services in the State Department of Health. Staff assigned to family planning services include: one obstetrical nurse, full-time; one MCH director, 25–50 percent time; one clinical supervisor, 25–50 percent time; one clinical supervisor, full-time; one secretary, 25–50 percent time; one key punch operator, 10–25 percent time; and one key punch operator, 25–50 percent time.

The Department performs the following functions in support of family planning activities: con-

sultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; provision of cytology services; review of Department of Public Welfare and OEO family planning projects; and assistance to local communities in developing new programs.

4. *Financing*:³ \$476,029 of new MCH funds were allocated to the State Department of Health in FY 1971 which were federally earmarked for family planning; \$469,970, or 98.7 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$2,108,291. An estimated \$127,000 of these funds were spent for family planning services. The Department received no specific legislative appropriation for family planning in FY 1971. The Department matched DHEW National Center for Family Planning Services Grants totaling \$908,417 used in four local projects in FY 1971. The state contribution to these projects was \$325,936.

5. *Voluntary Sterilization*: The State Department of Health has no written policy with regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in Texas is contained in Sections 4300 through 4340 of the *Department of Public Welfare Social Services Handbook*, dated November 1970. Section 4310 states: "Failure and/or inability of AFDC families to schedule births . . . creates economic, emotional and health stresses, impairing the establishment or continuation of constructive family life. Such stresses are reflected in increased demands on limited financial resources, interrupted employment or training of parents, excessive claims upon parental time and energy, increased risk to maternal and child health during pregnancy and following birth, etc." The "Department Goal" in regard to family planning is, according to Section 4320, the "elimination of familial and personal obstacles which prevent AFDC parents from utilizing desired family planning services."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. Local welfare agencies are *authorized* but not required to purchase medical family planning services for these recipients. Paragraph 3 of Section 4340 indicates that "If no family planning services are available the agency will develop such resources for the individual."

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. However, the Department reported: "Medical payment is made only in contract service projects unless the service is part of medical treatment prescribed by a physician."² The Department has at least two purchase of service contracts with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are eligible for referral services only unless they reside in areas covered by "service projects purchased under assistance title contracts." General Assistance recipients are not eligible for medical family planning services.

There are no additional limitations which affect the provision of services to adults or minors. Section 4330 states that family planning "services must be available without regard to marital status, age or parenthood."

4. *Administration:*⁴ The Social Service Division and the Medical Service Division in the Department of Public Welfare share administrative responsibility for the family planning program. No staff are assigned either full- or part-time to family planning. Family planning activities of these divisions include the training of local welfare staff and the development and distribution of educational materials.

5. *Financing:*⁵ The Department of Public Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Public Welfare has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local agencies. Local agencies are authorized to pay for sterilization procedures provided to eligible public assistance recipients.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Texas Medicaid program, family planning services are "Not Provided." However, this publication is based on data as of January 1970 and the Texas Medicaid program may have been modified since that date. (For additional information on Medicaid see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey, unless otherwise indicated.
4. Ibid.
5. Ibid.

Utah

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Utah.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

Utah's Prophylactic Control Act regulates "prophylactics," defined as devices used in the prevention of venereal disease. Utah Code Ann. §§ 58-19-1 to 58-19-11 (1963). The statute prohibits the selling or giving away of prophylactics except by a licensee under the statute. An exception is made of physicians who dispose of prophylactics in their regular practice and to their patients. The State Board of Health is empowered to decide which appliances and devices are "prophylactics" within the meaning of this act, and is directed to publish a list of them. The sale of these prophylactics is to be automatically restricted to licensees. The sale of prophylactics by vending machine is prohibited.

There are two kinds of licenses:

- Wholesaler—those issued this kind of license may sell in the usual wholesale manner but only to licensees. A manufacturer who has a wholesaler license may sell only to one who holds a wholesaler or retailer license. An exception provides that wholesalers may sell to physicians.

- Retailer—issued only to pharmacies. A retailer may sell to other licensees; to physicians, or upon their order; and to any person other than unmarried individuals younger than 18. Sales must be confined to the place of business for which the license was issued.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

Display of prophylactics, defined above, is prohibited in show windows facing public streets or highways, upon the streets or in public places. Advertising is prohibited in magazines, newspapers or other publications, billboards, radio, etc. An exception exempts medical and drug publications; publications having interstate circulation originating outside of Utah and which satisfy federal standards; and the furnishing to a qualified purchaser within the place of business of a licensee, printed or other informa-

tion needed in relation to prophylactics. Utah Code Ann. §58-19-10 (1953).

4. *Laws Relating to Contraceptive Services to Minors:* "The period of minority extends in males to the age of 21 years and in females to that of 18 years; but all minors obtain their majority by marriage." Utah Code Ann. § 15-2-1 (1962).

"When at the time of marriage the male is under sixteen or the female is under fourteen years of age" the marriage is "prohibited and declared void." Utah Code Ann. § 30-1-2 (1969). Minors need written parental consent in order to be issued a marriage license. § 30-1-9. In *State v. Huntsman*, 115 Utah 283, 204 P. 2d 448, 450 (1949) the court said: "Although a marriage license may not issue to a female under 18 years without the consent of her parents or guardian, she is capable of consenting to marriage at 14 years of age." In *State v. Stewart*, 57 Utah 224, 193 Pac. 855 (1922) the court held that even where a marriage license is issued to a minor without written parental consent, the marriage is not void unless the male is younger than 16 or the female younger than 14.

In *Jane Doe v. Planned Parenthood Association of Utah* (Memorandum Decision No. 204803, District Court, Salt Lake City, May 15, 1972) a lower state court held that it would be unconstitutional to deny plaintiff (a 16-year-old female), and all others similarly situated not under the age of 14, family planning services. The court found that the Planned Parenthood Association of Utah had "an affirmative duty, under its present contract [with the U.S. Office of Economic Opportunity] and under the laws establishing its program, to provide Family Planning Assistance and services to the plaintiff and all others similarly situated not under the age of fourteen." The court further stated that it was "not unaware of some segments of the community which are opposed to controlling parenthood. However, in this Court's experience of sixteen years the Court has kept statistics in connection with consents to adoptions given by unwed mothers, and from those statistics it is clear to the Court that 90 percent of those giving consents were between the ages of fifteen and nineteen." (This case involved a 16-year-old female who was refused contraceptive services by the Planned Parenthood Association of Utah and thereafter became pregnant.)

There is a difference of opinion between the district court in Salt Lake City and the State Attorney General about the provision of contraceptive services to minors—at least those minors above the age of 14. The court has held that the Planned Parenthood Association of Utah is constitutionally required to provide such minors with contraceptive services, if they request them. However, a recent but prior Attorney General's opinion advises the Utah Division of Family Services *not* to provide family planning information or services to minors without parental consent "until such time as the state legislature may adopt appropriate legislation." Op. Atty. Gen. No. 71-017, July 21, 1971. In support of this view the Attorney General cites the common law requirement of parental consent in the absence of an emergency, plus the expression of legislative intent inferred from the statute dealing with prophylactics, discussed in the "Laws and Court Decisions Relating to Sale and Distribution of Contraceptives."

The above-cited Attorney General's Opinion cites no Utah cases but states that medical care may be furnished to an unwed *pregnant* minor without the consent of a parent or guardian, on the ground that an emergency exists. The opinion states: "As a practical matter, this may be construed as emergency assistance where it is apparent that if parental consent is necessary, the minor will not submit to care and may instead seek an unlawful termination of pregnancy. In that respect the pregnancy situation differs from the contraceptive situation. There is some urgency involved." In making this distinction and calling the "pregnancy situation" urgent and therefore an emergency and the "contraceptive situation" not urgent, the Attorney General appears not to have considered the high probability that sexually active females who do not obtain contraceptive protection will become pregnant.

We have found no cases indicating whether the Utah courts would follow the general pattern of permitting medical treatment for emancipated minors without parental consent or whether Utah courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

We have seen that by statute, prophylactics may be distributed only by physicians or licensed wholesalers or pharmacies. Pharmacies may sell prophylactics to other licensees, to physicians or upon their order, to any married persons and/or to any person over 18 years of age.

Any minor who is or professes to be afflicted with a venereal disease may consent to medical care by a licensed physician, and the consent of no other person shall be necessary. Utah Code Ann § 26-6-39.1 (1971 Supp.). The consent is valid whether or not the minor's professed suspicion of venereal disease is subsequently medically substantiated.

Under Utah law, a "neglected child" is defined to include "a child whose parent, guardian or custodian fails or refuses to provide proper or necessary . . . medical care, including surgery and psychiatric services when required, or any other care necessary for his health, morals or well-being." Utah Code Ann. § 55-10-64 (17) 1971 Supp.) The juvenile court has exclusive jurisdiction in proceedings concerning "neglected" children. § 55-10-77 (2) (a). "Upon the sworn testimony of one or more reputable physicians, the court may order emergency medical or surgical treatment which is immediately necessary for a child concerning whom a petition has been filed pending the service of summons upon his parents, guardian, or custodian." § 55-10-87 (5).

B. Laws Relating to Voluntary Sterilization

A Utah "compulsory sterilization" statute which might appear to declare voluntary sterilization a felony, except for medical necessity, has been adjudged by a Utah District Court as applying only to institutionalized persons, and not as prohibiting voluntary sterilization of noninstitutionalized persons. This decision has been appealed to the Utah Supreme Court.

Utah's compulsory sterilization statute covers certain inmates of state prisons and hospitals, such as sexual criminals, idiots, epileptics and people adjudged insane. This statute provides:

Except as authorized by this chapter, every person who performs, encourages, assists in or otherwise promotes the performance of any of the operations described in this chapter for the purpose of destroying the power to procreate the human species, unless the same shall be a medical necessity, is guilty of a felony. Utah Code Ann. § 64-10-12 (1968).

The statute also contains a provision that "nothing in this chapter shall be construed to prevent the medical or surgical treatment, for sound therapeutic reasons, of any person by a physician or surgeon licensed by this state, which treatment may incidentally involve the destruction of the reproductive functions." Utah Code Ann. § 64-10-11 (1968).

Section 64-10-12 was recently construed by a Utah Court as applying only to institutionalized persons. The court said:

[S]aid statute does not prohibit any and all persons in the State of Utah who are not institutionalized from voluntarily undergoing an operation for the purpose of being sterilized, that is, destroying the power to procreate. *Parker, et al v. Rampton, et al*, Dist. Ct. Salt Lake County, Utah, Civil Judgment #195446, April 8, 1971.

The court enjoined law enforcement officers from enforcing the provisions of Section 64-10-12 except as to the inmates and patients in state institutions to whom the statute specifically applies.

As the court sees it, Section 64-10-12 is designed

only to insure that no one is sterilized under the compulsory sterilization statute unless all the safeguards provided therein are duly observed. This view is supported by the fact that the provision is located in the compulsory sterilization law. This case is now pending for decision on an appeal to the Utah Supreme Court.

Although the present Attorney General of Utah takes the position that § 64-10-12 is not limited in its application to the institutionalized persons specified by the statute, his predecessor in office published a contrary opinion which said:

This provision should be interpreted as a limitation and check on officials vested with the authority under this section of seeking the sterilization of institutionalized persons. The obvious purpose is to insure that statutory procedures set forth in this section are not disregarded. Opinion of Attorney General Phil L. Hansen, No. 68-040, July 17, 1968.

With regard to Section 64-10-11, Attorney General Hansen stated:

This office interprets the provision set forth above as intended to protect physicians or surgeons who, in treating institutionalized persons, are required as an incident of that treatment to destroy the reproductive functions. This provision provides protection from the application of Repl. Vol. Utah Code Ann. § 64-10-12 (1961) previously quoted, because in the usual case arising under the provision exempting legitimate treatment by a physician, the statutory procedures for sterilization cannot be observed.

The opinions advanced by this office are reinforced by the fact that every provision dealing with sterilization as such is found within Title 64 entitled "State Institutions."

Therefore, there is nothing in the Utah Code to prevent voluntary sterilization in cases involving noninstitutionalized persons. *Ibid.*

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current written policy on family planning of the Utah State Division of Health consists of a "Policy Statement on Family Planning," adopted by the Utah State Board of Health on June 16, 1965. The policy states: "The Utah State Board of Health . . . strongly supports the concept of 'family planning'." The policy urges "the development of family life education programs . . . [and] encourages individuals to seek medical assistance with the problem of conception, of planned and wanted children." The policy states that family planning assistance should be provided by physicians or through programs supervised by a physician. The policy states that family planning services should be made available in a manner consistent with the desires and beliefs of potential patients. It also states that "it is considered appropriate for state and local health department personnel to participate in appropriate ways in carrying out this policy wherever the matter of family planning is re-

lated to state and local health department activities." State health department funds may be used to support these activities.

2. *Eligibility:*¹ Eligibility requirements for family planning services are not established in the Division of Health policy cited above. Apart from written policy, the Division indicated in the CFPPD survey that adults and married minors are eligible for family planning services; all other minors must have parental consent. Family planning services in Division of Health clinics are free. Persons served in health agency clinics must be residents of the state and of the appropriate county, according to the Director of Health.

In addition to the "Policy Statement" cited above, the State Division of Health, in verifying its current policies for this study, included a copy of an opinion by the State Attorney General prepared for the Director, Division of Family Services, Department of Social Services, regarding the provision of family planning services to minors. The opinion advises the welfare agency against providing family planning information or counseling or purchasing medical contraceptive services for minors without parental consent. (See Laws on Minors, above, and Welfare Agency Policy, Eligibility, below.)

3. *Administration:*² Administrative responsibility for family planning services is not assigned to a specific subunit of the State Health Division. The following staff are assigned to family planning activities in the Division: the Director of Special Health Services, 10-25 percent time; the MCH section Chief, 10-25 percent time; one consultant nurse, full-time; one consultant nurse, 10-25 percent time; and one nurse coordinator, less than 10 percent time.

The Division of Health performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; purchase or provision of supplies, equipment or other materials to local family planning programs for support of services; and provision of direct services in areas where health departments are not well established.

4. *Financing:*³ \$70,838 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked family planning funds for FY 1971 was \$334,024; \$17,162 of these funds were spent for family planning. The Division of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the health agency for family planning services.

5. *Voluntary Sterilization:* The Division of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Utah is contained in Section 4670 of the *Manual of the Department of Social Services*, dated November 1968. Additional policy statements are contained in the *Manual of the Division of Family Services* in Volume IV, Section T-4135, dated March 1970, and in Section 5424, dated August 1969. Subsection 4672 of the *Manual of the Department of Social Services* defines family planning services as "those social services which are directly related to alleviating personal and family problems which can be attributed to the size of the family, and the spacing of children, or potential pregnancies which would be detrimental to the health and well-being of the mother." According to Subsection 4673: "Family planning has at least three objectives: 1) The welfare of each individual child; 2) The welfare of the family; 3) The welfare of society and the world at large. Families should be enabled to space births, so infants have a better chance of growing up in a healthy family atmosphere, families are given a better chance of developing sound, meaningful, rewarding family relationships."

A 1971 Attorney General opinion prohibits the Department of Social Services from providing family planning services to unmarried minors without parental consent. Op. Atty. Gen. No. 71-017, July 21, 1971. (See Law on Minors, and Health Department Policies, Eligibility, above, and Eligibility section below).

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department of Social Services recommends that local welfare agencies refer eligible public assistance recipients to medical family planning services. The Department reported that "payment for these services . . . is paid by the State Division of Family Services."

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies, and private physicians. The Department reported that "Planned Parenthood of Utah" is also authorized to receive reimbursement under the policy. The Department also reported that there is a single, standard, statewide reimbursement rate for medical family planning procedures which pays "\$20 to private physicians" for the insertion of an IUD.

"The rate of payment to private physicians for most services is 80 percent of usual and customary fees." ² The Department has contracts and/or other formal arrangements "with Planned Parenthood of Utah and the State Division of Health" for the provision of family planning service. The Division of Family Services reported that it "has a contract with Planned Parenthood of Utah clinics to pay \$20 per year per person served."

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance and residents of low-income areas are not eligible for medical family planning services. General Assistance recipients are not eligible for medical family planning services.

There are no additional limitations that affect the provision of services to adults. Parental consent is required for the provision of services to all minors except those that are married. The opinion of the Attorney General, referred to above, states that the question of the provision of services to minors "is of such an important and charged nature as to be best suited to legislative treatment rather than administrative rule-making." According to Section T-4135, "Family Planning services shall not be provided minors without parental consent." Under Utah law, all minors obtain majority by marriage. (See Law on Minors, above).

4. *Administration:*⁴ The Division of Family Services in the State Department of Social Services has administrative responsibility for the welfare family planning program. The Division reported: "The Governor recently formed an Ad-Hoc Committee on Family Planning to identify who is doing what and to make recommendations, possibly for a commission to oversee and coordinate family planning activities in the State." No staff are assigned either full- or part-time to family planning. The Division's family planning activities include a "minimum effort" in the training of local welfare staff and the development and distribution of public educational materials.

5. *Financing:*⁵ The Department of Social Services received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department reported in the CFPPD survey that sterilization procedures are "illegal" in Utah. However, a 1971 District Court decision (on appeal) ruled that voluntary sterilizations were not prohibited for the noninstitutionalized population (See Laws on Sterilization, above).

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Utah Medicaid program, family planning services are "Provided. No limitations, but must be on physician's prescription.... Reimbursement on basis of fee schedule." The extent of utilization of the Medicaid program for family planning

services is unknown. (For additional information, see Federal Laws and Policies Section of this report.)

3. As reported in CFPPD survey, unless otherwise indicated.
4. Ibid.
5. Ibid.

Vermont

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Vermont.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 18. Vt. Stat. Ann. tit. 1, § 173 (1972) (as amended by Act No. 90, Public Acts of 1971).

If a minor of 12 years of age or older is suspected of having venereal disease (or being dependent on drugs), and the finding of such disease (or dependency) is verified by a licensed physician, the minor may consent to medical treatment and hospitalization if deemed necessary for diagnosis or treatment of such disease (or dependency), and the consent of the parent or guardian shall not be necessary. The parent, parents or legal guardian must be notified by the physician if the condition of a minor child requires immediate hospitalization for the treatment of a venereal disease (or as a result of drug usage). Vt. Stat. Ann. tit. 18, § 4226 (Cum. Supp. 1971).

Although no cases were found regarding the right of an emancipated minor to consent to his own medical treatment, Vermont courts view emancipation as an extinguishment of parental rights and duties (see cases discussed below) and would probably accept the common law rule that an emancipated minor can consent to his own medical care. In *Bonneau v. Russell*, 117 Vt. 134, 85 A. 2d 569 (1952), it was held that marriage emancipates a minor and that "when emancipated he has the control of himself, is not subject to the restraint of his parents, and may remove himself from the town of their residence. An emancipated child can acquire a domicile of choice."

Vermont courts have repeatedly held that marriage emancipates a minor. *Bonneau v. Russell*, *supra*; *Town of Sherburne v. Town of Hartland*, 37 Vt. 528 (1864); *Town of Craftsbury v. Town of Greenboro*, 66 Vt. 585, 29 Atl. 1024 (1894).

A marriage license may not be issued when the prospective groom is younger than 16 or the prospective bride is younger than 14. Vt. Stat. Ann. tit. 18,

§ 5142 (1968). A marriage license may not be issued to any minor without the consent of one of the parents or the guardian of the minor, Vt. Stat. Ann. tit. 18, § 5142 (Cum. Supp. 1971), nor with such consent when the prospective bride is younger than 16 unless a judge certifies that the public good requires such a license to be issued. Vt. Stat. Ann. tit. 18, § 5142 (1968).

A minor who enlists in the U.S. Army with his father's consent is emancipated for at least as long as his enlistment continues, *Baker v. Baker*, 41 Vt. 55 (1868). A minor was held to have been emancipated by his parents when he was given away at the age of 18 months. *Tunbridge v. Eden*, 39 Vt. 17 (1865). The court in the *Tunbridge* case said, "The new relation, inconsistent with the relation of parent and child, which constitutes emancipation, may be contracted by the minor by consent of his parents, as in case of marriage; or if the minor be an infant, the new relation may be contracted by his parents for the infant."

Vermont has also recognized the doctrine of "partial emancipation" in cases where a father allows a son to keep his earnings. In *Tillotson v. McCrillis*, 11 Vt. 477 (1839), a son was held emancipated with regard to certain earnings even though he later turned over other earnings to his father. The court said:

That a father may give to his infant son his time, who thereupon will be entitled to the fruit of his earnings, has been fully decided in this state. There can be no reason why he may not give him a part of that time.

In *Bray v. Wheeler*, 29 Vt. 514 (1857), the court held that a father could give his son his time and earnings—which earnings could therefore not be reached by the father's creditors—even though the son was only 13.

In *Atkins v. Sherbino*, 58 Vt. 248, 4 Atl. 703 (1885), a father who knew that the defendant was paying his 16-year-old son wages and did not object was not permitted later to sue the defendant for the son's wages, regardless of whether the defendant knew of the son's "total or partial emancipation by the father."

Vermont courts have stated that the emancipation of a minor is not presumed, but must be proved, *Hardwick v. Pawlet*, 36 Vt. 320 (1863), and that the emancipation of a minor does not enlarge or affect

his capacity to make a contract. *Person v. Chase*, 37 Vt. 647 (1865).

Until 1967, Vermont had a statute regarding municipal poor relief which set forth the various ways in which a minor could gain a separate settlement for poor relief purposes. That statute provided:

A minor may gain a separate settlement as follows: (4) If emancipated, by supporting himself continuously for three years, but a minor shall not acquire a separate settlement by reason of serving an apprenticeship, or securing an education in any educational institution, or where such minor is dependent in whole or in part upon his parent or guardian for support. Vt. Stat. tit. 33, § 744 (repealed 1967).

This law was repealed in 1967 and replaced by new provisions regarding aid and services to needy families with children (Vt. Stat. Ann. tit. 33, Ch. 32, Cum. Supp. 1971) and medical assistance under Title XIX of the Social Security Act (Vt. Stat. Ann. tit. 33, Ch. 36, Cum. Supp. 1971), but it may still be indicative of the meaning of the Vermont common law on minors.

We have found no cases indicating whether Vermont courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies or whether Vermont courts would accept the "mature minor rule" discussed in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

Under Vermont law, a "neglected child" is one who has been abandoned or who is "without proper parental care or control, or subsistence, education, medical or other care or control necessary for his well-being." Vt. Stat. Ann. tit. 33, § 632 (a) (12) (Cum. Supp. 1971). "The commissioner of social welfare and the commissioner of corrections may incur such expenses for the proper care, maintenance and education of the [delinquent or neglected] child, including without limitation the expenses of medical, surgical or psychiatric examination or treatment as he considers necessary . . ." Vt. Stat. Ann. tit. 33, § 660 (Cum. Supp. 1971).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* There is no official State of Vermont Department of Health policy on family planning. According to the Division of Child Health Services, that Division operates under the federal mandate "of protecting and promoting the health of mothers and children." In the Child

Services state plan there is a statement that family planning services within the state are supported through the Child Health Services Division.

2. *Eligibility:*¹ Eligibility requirements for family planning services are determined by local agencies. No patient fees or payments are in effect in local family planning programs.

3. *Administration:*² Administrative responsibility for family planning services is not assigned to a specific unit in the Department of Health. The Director of the Division of Child Health Services is Project Director for a federally financed family planning project which is operated under subcontract by the Planned Parenthood Association of Vermont, Inc. (The project is financed with a Special Project Grant for Family Planning under Title V of the Social Security Act.) The Director of Child Health Services devotes 10 percent time to family planning activities officially, and more unofficially, according to the Division.

The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$9,030 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of non earmarked MCH funds for FY 1971 was \$186,301. An estimated \$44,320 of these funds were spent for family planning services. The Department of Health received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the state health agency for family planning.

5. *Voluntary Sterilization:* The Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare fam-

ily planning policy in Vermont is contained in two memoranda issued by the Commissioner of Social Welfare in November 1967 and in *Social Welfare Bulletin No. 69-20* issued by the Commissioner in January 1969. *Bulletin 69-20* states that "we now consider family planning as no different from any other service, i.e., its availability will be made known as appropriate. Whether or not an individual avails himself of family planning services remains a matter of individual decision." The *Bulletin* also provides: "For the individual who decides to engage in some regimen of family planning, medical consultation is available throughout the state, through private physicians or Family Planning Clinics. Certainly, advice as to the efficacy or desirability of one method or another is not within the scope of caseworker competence—our role at that point is one of referral only." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ The Board of Social Welfare policy as quoted in *Bulletin No. 69-20*, states: "The availability of family planning counseling will henceforth be made known to recipients of public welfare assistance as a matter of departmental policy. . . . A caseworker is to consider family planning counseling and referral as one facet of many services available to welfare clients.' " There is no information as to whether local welfare agencies are authorized to purchase medical family planning services for eligible public assistance recipients.

The policy, however, authorizes reimbursements to hospital outpatient clinics, "participating" voluntary agencies, and private physicians. Health departments are not authorized to receive reimbursement under the policy. There is no single, standard, state-wide reimbursement rate for medical family planning procedures.² The Department has no contracts

and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance, General Assistance recipients and residents of low-income areas are not eligible for medical services. The policy contains no additional limitations that affect the provision of services to adults or minors. There is no information as to whether parental consent is required for the provision of services to minors.

4. *Administration*:⁴ Administrative responsibility for the welfare family planning program is not assigned to any particular subdivision in the Department of Social Welfare. The Department has no staff assigned to family planning activities.

5. *Financing*:⁵ The Department of Social Welfare received no specific appropriation for family planning services from the state legislature in FY 1971.

6. *Voluntary Sterilization*: The Department of Social Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Vermont Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices. No limitations. . . . Reimbursement of physician on basis of usual and customary charge." The extent of utilization of the Medicaid program for family planning services is unknown. For additional information on Medicaid see Federal Laws and Policies Section of this report.
3. As reported in CFPPD survey.
4. Ibid.
5. Ibid.

Virginia

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Virginia.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

The sale or disposal of devices for the prevention of venereal disease is limited to licensed practitioners of medicine, and licensed pharmacies and retail outlets. Va. Code Ann. § 18.1-203 (1960). Wholesalers regularly transacting business as such may sell only to licensed retailers. The statute also prohibits the sale by vending machine of devices for the prevention of venereal disease. This prohibition against the sale of prophylactics by vending machine was held constitutional in *Cavalier Vending Corp. v. State Board of Pharmacy*, 195 Va. 626, 79 S.E. 2d 636 (1954), appeal dismissed, 347 U.S. 995 (1954). The Court held that the sale of prophylactics solely by licensed retail outlets was justified to discourage their improper or immoral use. According to the court, the state was only regulating the sale of prophylactics, and not attempting to prohibit their sale since all licensed pharmacies and retail stores could sell them.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority for most purposes including consent to general medical care has been reduced to 18. House Bill 378, effective July 1, 1972. Virginia law specifically provides that "any person under the age of eighteen years may consent to medical health services . . . required in case of birth control, pregnancy and family planning" Va. Code Ann. § 32-137 (as amended by House Bill 378, effective July 1, 1972). Persons younger than 21, however, may not consent to sterilization, and minors younger than 18 may not consent to abortion.

The Attorney General of Virginia has stated that, under § 32-137, "with the exception of abortion, any mentally competent person, regardless of age, marital status, or emancipation can validly consent to any medical, surgical, or health services . . . in those categories which are enumerated in the statute

and the consent of the parent, guardian, or other person standing in loco parentis is unnecessary." Letter from Attorney General Andrew P. Miller to the Hon. Mack I. Shanholtz, M.D., State Health Commissioner, April 28, 1971.

Any minor may consent to examination and treatment for venereal or any other reportable infectious or contagious diseases. Va. Code Ann. § 32-137 (as amended by House Bill 378, effective July 1, 1972).

Virginia also has statutory provisions for medical treatment of minors younger than 18 who have been separated from the custody of their parents or whose parents cannot be consulted with promptness.¹

Footnote:

1. Whenever "any person who is under eighteen years of age and who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment," authority to consent to such treatment is conferred:

(1) Upon judges and trial justices with respect to children whose custody is within the control of their respective courts.

(2) Upon the Commissioner of Public Welfare with respect to any ward of the Board of Welfare and Institutions.

(3) Upon the principal executive officers of State institutions with respect to the wards of such institutions.

(4) Upon the principal executive officer of any other institution or agency legally qualified to receive children for care and maintenance separated from their parents or guardians, with respect to any child whose custody is within the control of such institution or agency.

(6) Any person standing in loco parentis, conservator or custodian for his ward or other charge under disability. Va. Code Ann. § 32-137 (as amended by House Bill 378, effective July 1, 1972.)

The same statute provides:

Whenever the consent of the parent or guardian of any person who is under eighteen years of age and who is in need of surgical or medical treatment is unobtainable because such parent or guardian is not a resident of this State or his whereabouts is unknown or cannot be consulted with promptness, reasonable under the circumstances, authority, commensurate with that of a parent in like cases, is conferred, for the purpose of giving consent to such surgical or medical treatment, upon judges of juvenile and domestic relations courts.

B. Laws Relating to Voluntary Sterilization

A Virginia statute authorizes and sets forth special procedures for the performance of voluntary sterili-

zation operations on any person 21 years of age or over. Va. Code Ann. §§ 32-423, 32-425, 32-426, 32-427 (1969).

The surgical procedures authorized are vasectomy and salpingectomy. Both procedures must be performed in a licensed hospital. § 32-423.

The request for sterilization must be made in writing at least 30 days prior to the operation by the person to be sterilized and, if married, also by his or her spouse. The spouse's request is not necessary if the person seeking sterilization states in writing under oath that his or her spouse has disappeared or that they have been separated continuously for a period of more than two years prior thereto. § 32-423.

Prior to or at the time of the request for sterilization, a full and reasonable medical explanation must be given by the physician or surgeon to the patient as to the meaning and consequences of the operation. § 32-423.

The physician or surgeon performing the operation must be duly licensed and must consult or collaborate with at least one other physician or surgeon so licensed. § 32-423.

No operation may be performed until 30 days from the date of consent or request therefor nor if the consent is withdrawn. § 32-425.

The statute exempts licensed physicians and surgeons performing authorized sterilization procedures from civil and criminal liability except for negligence. § 32-426.

Virginia also has a statute which provides for the compulsory sterilization of patients in state hospitals afflicted with certain forms of mental illness or mental deficiency. This statute contains the following provision:

Nothing in this chapter shall be construed so as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this state, by a physician or surgeon licensed by this state, which treatment may incidentally involve the nullification or destruction of the reproductive functions. Va. Code Ann. § 37.1-171 (1970).

In other words, if an operation such as removal of a cancerous womb or prostate gland is performed by a licensed physician or surgeon on a person who is otherwise subject to the provisions of the compulsory sterilization law (i.e., a person afflicted with hereditary mental illness or mental deficiency), the procedures prescribed in that sterilization law need not be followed although the operation may result in sterilization of the patient. See Letter from Attorney General Andrew P. Miller to the Hon. Dabney Watts, Commonwealth's Attorney for the City of Winchester, June 9, 1971 (discussed below under Minors).

Moreover, if such an operation (for reasons of medical necessity) is performed on a person not sub-

ject to the provisions of the compulsory sterilization law, the procedures set forth above for voluntary sterilization also need not be followed. See Va. Code Ann. § 32-427 (1969).

Minors: The Virginia statute authorizing voluntary sterilization as originally enacted applied only to persons "21 years of age or over" (see above). In 1971, Section 32-137 of the Virginia Code was amended to provide that any person younger than 21 could consent to medical or health services "required in case of birth control, pregnancy and family planning" (see Laws Relating to Contraceptive Services to Minors, above). The Attorney General of Virginia thereupon expressed the opinion that voluntary sterilization was a health service used as a means of birth control and that minors could, therefore, effectively consent to be sterilized for contraceptive purposes without the consent of a parent or guardian. Letter from Attorney General Andrew P. Miller to the Hon. Charles L. McCormick III, Commonwealth's Attorney for Halifax County and City of South Boston, Oct. 19, 1971.

The Virginia legislature has rejected this interpretation of the law. At the same time that it reduced the age of majority to 18 for most purposes including consent to medical care (House Bill 378, effective July 1, 1972), the legislature amended and reenacted the voluntary sterilization law. As amended, the law authorizes and sets forth special procedures for the voluntary sterilization of "any person who has attained the age of twenty-one years." House Bill 291, effective July 1, 1972. The use of this language in a statute enacted after Section 32-137 makes it clear that persons under 21 may not consent to sterilization in Virginia.

The new law also partially invalidates an earlier Attorney General's opinion rendered with respect to a salpingectomy to be performed on a 16-year-old girl. Letter from Attorney General Andrew P. Miller to the Hon. Dabney Watts, Commonwealth's Attorney for the City of Winchester, June 9, 1971. Because of impaired renal function, further pregnancy threatened the girl's life. The girl was not afflicted with mental illness or mental deficiency. The Attorney General was asked whether Section 37.1-171 (quoted above) would permit such surgery, and if so, who could consent to the operation. In reply, the Attorney General first discussed Section 32-424 of the Virginia law. This section sets forth procedures for the sterilization of persons under 21 who are afflicted with certain forms of mental illness or mental deficiency; the required procedures include a court order. In the opinion of the Attorney General, cited above, this section, although located in the voluntary sterilization law, is actually a eugenic sterilization statute and applies only to persons afflicted with mental illness or mental deficiency. The Attor-

ney General stated that, since the proposed procedure was both therapeutic and contraceptive, as distinguished from eugenic, it came within the scope of Section 37.1-171 (see above) and the procedures set forth in Section 32-424 did not have to be followed. Up to this point, the validity of the opinion would appear unaffected by the new law. However, the Attorney General went on to say that, under Section 32-137 (see above), the 16-year-old girl could consent to the procedure, and parental or court consent was not necessary. This portion of the Attorney General's opinion has been rendered obsolete, at least with regard to the necessity of parental consent, by the reenactment by the legislature of the sterilization law with a newly worded requirement that the person requesting sterilization have "attained the age of 21."

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* Current Department of Health policy on family planning consists of a letter from the Commissioner of Health to local health officers regarding "Policy Relative to Planned Parenthood Services," dated June 18, 1962. The policy states that "family planning will be considered an integral part of family health services. Local health departments will be expected to take positive action to implement this activity. . . . Patients under the supervision of local MCH clinics will be provided with such contraceptive equipment and supplies as may be prescribed by the acting clinician. . . . Health education materials relative to family planning will be provided on request to local health departments. . . ."

2. *Eligibility:*¹ While not specified in the policy cited above, social and geographical eligibility criteria are recommended by the Department of Health. Under the recommended policy, all categories of adults and minors (the latter without requirement of parental consent) are eligible for family planning services. Patients are urged to "attend the nearest facility, but this recommendation is not a requirement." Financial eligibility requirements and patient fees or payments are determined by local health agencies. However, the state health agency recommends that no fees be charged for family planning drugs or devices.

3. *Administration:*² The Bureau of Family Planning has administrative responsibility for family planning services in the Department of Health. Staff assigned to family planning services include the following full-time personnel: one family planning director, one information officer, one clerk stenographer, and one clerk typist.

The Department performs the following functions in support of family planning activities: consulta-

tion; training; development and distribution of public educational materials; purchase or provision of supplies, equipment or other materials to local family planning programs; and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$224,501 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning; \$164,703, or 73.3 percent of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$1,101,080. An estimated \$141,447 of these funds were spent for family planning services. The Department of Health received no specific appropriation for family planning services from the state legislature in FY 1971. No other state funds were utilized by the state health agency for family planning in FY 1971.

5. *Voluntary Sterilization:* The Department of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Virginia is contained in *Guide Material* released to local welfare departments in July 1970. Additional family planning policy is found in *Bulletin 477*, dated June 1969 and *Bulletin 464*, dated September 1968 of the Virginia Department of Welfare and Institutions. The *Guide Material* defines agency responsibility, outlines the role of the caseworker and states that the objectives of the family planning program are: 1) To strengthen family life; including preventing or reducing the incidence of births out-of-wedlock; 2) To protect and promote the health of mothers and children; 3) To assist families in attaining and maintaining the opportunity to determine family sizes they desire; 4) To assist families in the spacing of their children; 5) To decrease maternal and infant mortality and morbidity; 6) To decrease the incidence of mental retardation and congenital defects; 7) To decrease the incidence of prematurity; 8) To improve understanding of family life and sex education; 9) To lessen school dropout rate.

Paragraph 6 in *Bulletin 477* states: "Family planning is basically a medical responsibility." In May 1971, the Department issued a *General Release* to Superintendents of Public Welfare containing excerpts from an April 28, 1971 Attorney General's opinion ruling on a 1971 statute which states that parental consent is not required for the provision of "birth control, pregnancy and family planning" services to minors (See Laws on Minors, above).

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. However, the Department and local welfare agencies *do not* themselves purchase medical family planning services for eligible public assistance recipients.² The Department reported that "The client may go to a Health Department clinic or to a private physician." The Department has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance and applicants for such assistance are eligible for medical family planning services. Past and potential recipients of such assistance and residents of low-income areas are eligible for information and referral services only. The Department does not fund or administer a General Assistance program.

There are no additional limitations that affect the provisions of services to adults or minors. The 1971 statute and Attorney General's opinion cited above (See Laws on Minors) provides that with the exception of abortion, any mentally competent person can consent to any family planning services. This opinion and the *General Release* supersede parental consent requirements in Part IV of the *Guide Material*.

4. *Administration:*⁴ The responsibility for the administration of the family planning program rests with the Bureau of Family and Children's Services in the Division of General Welfare of the Virginia Department of Welfare and Institutions. One Child Welfare Specialist devotes 75 percent of her time to family planning activities.

The Bureau's family planning activities include the training of local welfare staff, the development and distribution of public educational materials for local welfare agencies, and cooperation and coordination with the Virginia League of Planned Parenthood.

5. *Financing:*⁵ The Department of Welfare and Institutions received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Department of Welfare and Institutions has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Department leaves the question of referral for sterilization procedures to the option of local welfare agencies.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Virginia Medicaid program, family planning services are "Provided. Including drugs, supplies and devices. . . . Payment made only to providers which have entered into a participation agreement with the State agency. Reimbursement on variable basis according to type of provider." The extent of utilization of the Medicaid program for family planning is unknown. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey, unless otherwise indicated.
4. Ibid.
5. Ibid.

Washington

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program.

Washington's Medicaid program, Wash. Rev. Code § 74.09.500 ff. (1970 Supp.) is administered by the State Department of Public Assistance, and is available to all those who are "in need" and who meet the eligibility requirements established by the Department. Section 74.09.510. The medical assistance to be furnished may include "physician's services, which shall include prescribed medication and instruction on birth control devices."¹

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

Under the Prophylactic Vendor Statute, the sale or distribution of prophylactics, defined as devices for the prevention or treatment of venereal disease, is prohibited without a wholesale or retail dealer's license. Wholesale dealers may sell only at wholesale; retail dealers may sell only at retail.² Wash. Rev. Code § 18.81.020 (1961). Licensed physicians and surgeons are exempted from the act. § 18.81.025. Section 18.81.030 of this law was amended in 1971 to provide that a retail dealer's license shall be issued "to any person holding a valid license to operate a pharmacy, dispensary, hospital or clinic, and to any public or private program engaged in venereal disease prevention or treatment, family planning or the care, treatment or rehabilitation of any person." In addition, the Board of Pharmacy is required to issue a retail dealer's license "in any area where it determines prophylactics are not readily available, and to any person or program where the local health officer determines that, in the interest of public health, prophylactics should be made available."³

Accordingly, the Board on Oct. 7, 1971, effective Nov. 30, 1971 authorized the sale of prophylactics from vending machines and in groceries.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* A 1971 law deleted reference to "the prevention of conception" from a statute prohibiting the display and advertising of indecent articles. Wash. Rev. Code § 9.68.030 (1971 Supp.). Thus, it is now legal to display and advertise contraceptives.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 18, except as otherwise specifically provided by law. Wash. Rev. Code § 26.28.010 (1971 Cum. Supp.). Persons aged 18 are deemed to be of full age for the purpose of making decisions "in regard to their own body and the body of their lawful issue whether natural born to or adopted by such person to the full extent allowed to any other adult person including but not limited to consent to surgical operations." Wash. Laws, 1971, 1st Ex. Sess. Ch. 292, § 2 (5).

In *In re Hudson*, 13 Wash. 2d 673, 126 P. 2d 765 (1942) the court followed the general common law rule requiring parental consent for medical treatment of minors. In *Smith v. Seibly*, 72 Wash. 2d 16, 431 P. 2d 719 (1967) however, the Supreme Court of Washington recognized an exception for the emancipated, and probably the mature, minor. The *Smith* case involved a vasectomy performed upon an 18-year-old married minor without parental consent. The court held that the minor was emancipated for purposes of consenting to surgery and could not later sue the doctor who performed the vasectomy.

Thus, even before the age of majority was reduced to 18, the court ruled that an 18-year-old married minor who earns his own living and maintains his own home:

...is emancipated for the purpose of giving a valid consent to surgery if a full disclosure of the ramifications, implications and probable consequences of the surgery has been made by the doctor in terms which are fully comprehensible to the minor. Thus, age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents are all factors to be considered in such a case. 431 P. 2d at p. 723.

Although basing its decision on emancipation of the minor, the court's language could be read as an endorsement of the "mature minor doctrine," discussed in the Summary and Analysis of State Laws Relating to Contraceptive Services to Minors.

A minor 14 years of age or older who may have come in contact with any venereal disease or suspected venereal disease may consent to medical and surgical care related to the diagnosis or treatment of such disease, and the consent of parents or guardian shall not be necessary. Wash. Rev. Code § 70.24.110 (1971 Supp.).

Persons who are 18 may contract marriage. Wash.

Rev. Stat. § 26.04.010 (1971 Cum. Supp.). A 17-year-old who wishes to marry needs the consent in writing of his or her parent or guardian in order to be granted a marriage license. Wash. Rev. Stat. § 26.04.210 (1971 Cum. Supp.). This section specifies conditions under which 17-year-olds may be issued a license, but does not declare a marriage celebrated in contravention of its terms void. Thus, in *Ex Parte Hollopeter*, 52 Wash. 41, 100 P. 159 (1909), it was held that a marriage involving a minor is valid even without parental consent.

With respect to minors who are younger than 17, Section 26.04.010 provides that "every marriage entered into in which either party shall not have attained the age of seventeen years shall be void except where this section has been waived by a superior court judge of the county in which the female resides on a showing of necessity."

Under Washington law, "All females who are married to a person of full age shall be deemed and taken to be of full age." Wash. Rev. Code § 26.28.020 (1961).

Before the age of majority was lowered to 18, this provision had impact on female minors who were at least 17 but younger than 21. Now that the age of majority is 18, it applies only to 17-year-olds. The statute however does not make a male minor of lawful age because of marriage. *Morgan v. Cunningham*, 109 Wash. 105, 186 P. 309 (1919). In this case, the court held that a male minor's marriage with the consent of his parents emancipated him but did not remove the civil disabilities imposed on him as a minor; emancipation served to free the minor from parental control and to give him a right to his own earnings. (This case involved the question of whether a mother who continued to support her married minor son could claim to be a "head of household" for purposes of the Homestead Law.)

Emancipation, whether express or implied, complete or partial, absolute or conditional, must be clearly proved, with the burden of proof resting on the one alleging emancipation. *American Products v. Willwock*, 7 Wash. 2d 246, 109 P. 2d 570 (1941); *De Lay v. De Lay*, 54 Wash. 2d 63, 337 P. 2d 1057 (1959); *Foran v. Kallio*, 56 Wash. 2d 769, 355 P. 2d 544 (1960); *Holmes v. Raffo*, 60 Wash. 2d 421, 374 P. 2d 536 (1962).

Some examples of how the Washington courts view emancipation follow:

In *American Products v. Willwock*, *supra*, the court held that the fact that a father paid his minor son wages for driving a truck did not of itself establish emancipation. (This case involved the question of whether the son was a "workman" for purposes of collecting Workmen's Compensation for an accident which occurred while the son was driving his father's truck.)

In *De Lay v. De Lay*, *supra*, the court held that the fact that a 14-year-old who, after his mother's death, went to live with relatives in another city and was supported by them while he attended high school, did not of itself show emancipation by the minor's father. (This case involved the minor's attempt to sue his father for a tort.)

In *Foran v. Kallio*, *supra*, the court found that an 18-year-old, attending college at his own expense, who was permitted by his parents to retain his earnings from his part-time and summer full-time jobs, and to spend such earnings as he pleased was partially emancipated even though he was living at home and paying no room or board. (This case involved an auto accident which occurred while the minor was driving a car he purchased with his earnings.)

Under Washington law it is a crime for a person to "wilfully omit . . . without lawful excuse, to furnish necessary . . . medical attendance for his or her child or stepchild . . . or ward . . ." Wash. Rev. Stat. § 26.20.030 (1971 Cum. Supp.). See *State v. Williams*, 4 Wash. App. 908, 484 P. 2d 1167 (1971); *State v. Parmenter*, 74 Wash. 2d 343, 444 P. 2d 680 (1968). A "wilful act or omission" has been held to mean an absence of lawful excuse or justification on the part of the accused parent. *State v. Ozanne*, 75 Wash. 2d 546, 452 P. 2d 745 (1969). The word "necessary" in the statute has been held to relate to "the minimum standard of the quality and quantity of . . . medical attendance that a parent is required by law to furnish a child" rather than to an absolute lack of medical attendance. *State v. Brown*, 52 Wash. 2d 92, 323 P. 2d 239, 241 (1958).

Any child younger than 18 is a "dependent child" if he or she is "grossly and wilfully neglected as to medical care necessary for his well-being." Wash. Rev. Stat. § 13.04.010 (1962). Children adjudicated "dependent" under this statute are considered wards of the state and they are "subject to the custody, care, guardianship and control of the court. . . ." (See *In re Hudson*, above.) The Attorney General has stated that where the parents or guardian of a minor child have permanently forfeited their right to custody and control of the child by neglecting to care for their child as required by law and morals, the courts may subject the child to surgical care without the consent of the parent or guardian. Op. Atty. Gen. 1945-46, p. 569.

Washington has a Medicaid statute authorizing medical assistance including birth control to persons in need which contains no age restriction. (See *Laws Establishing Family Planning Programs*, above.)

State health department policy specifies that all categories of minors are eligible for family planning services and parental consent is not required. The welfare department policy is to make available family planning information and services to "all women

of childbearing age" in the AFDC program, and no requirement of parental consent is specified (See Health and Welfare Policies, Eligibility, below).

Footnotes:

1. Note that many other states also provide for contraceptive services under their Medicaid programs. We have included Washington's statute in the state profiles, while excluding many others, primarily because the Washington statute specifically mentions "birth control" as an item that may be furnished under "physicians' services."
2. In *State v. Northwest Drug Co.*, 15 Wash. 2d 634, 131 P. 2d 956 (1942), a drug company was held not guilty of selling as a wholesaler without a wholesale dealer's license, as required by Section 18.81.020, when it sold two gross of prophylactics to an inspector of the State Board of Pharmacy. The inspector had no intention of reselling to users, and under the statutory definition, a wholesaler is one who sells to a person who sells or intends to sell direct to the user. Since there was no allegation or proof of this, charges against the drug company were dropped.
3. Under Section 18.81.030 before its amendment, retail dealers' licenses were issued only to licensed pharmacies, and sale and distribution was permitted only by the holder of a license in his place of business.

B. Laws Relating to Voluntary Sterilization

The two court decisions discussed below make clear that voluntary sterilization is legal in the State of Washington.

Smith v. Seibly, 72 Wash. 2d 16, 431 P. 2d 719 (1967), was an action for damages brought by a man upon whom a vasectomy was performed when he was 18 years old. The plaintiff claimed that because he was a minor at the time, he was not able to give valid consent to the procedure. He was afflicted with a progressive, incurable muscle disease, and had sought the sterilization because, being married and already having one child at the time, he was afraid that he would not be able to support additional children. The court held that the consent was valid (See Minors, below), and assumed that voluntary sterilization was legal.

Ball v. Mudge, 64 Wash. 2d 247, 391 P. 2d 201 (1964), was an action for damages against a physician who performed a vasectomy on the plaintiff, one year after which the plaintiff's wife became pregnant. She subsequently gave birth to a healthy child. The court upheld the jury's verdict for the defendant, on the ground that the jury was justified in finding that any negligence on the doctor's part was not necessarily the cause of plaintiff's fertility a year later; there was expert testimony regarding the possibility of recanalization. The court assumed the legality of voluntary sterilization.

The CFPPD survey indicates that the Division of Public Assistance requires referral and counseling and payment for voluntary sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them. (See Welfare Policy, Sterilization, below).

Minors: By statute in Washington, 18-year-olds can

consent to medical care, including surgical operations. Wash. Rev. Code § 26.28.010 (1970). (See Laws Relating to Contraceptive Services to Minors, above).

Even before that statute was passed, a Washington court had ruled (in *Smith v. Seibly*, discussed above), that a physician could perform a vasectomy on a married 18-year-old minor without parental consent. The court held that the minor, who earned his own living and maintained a home for himself, his wife and their child, was emancipated for the purpose of giving a valid consent to surgery if a full disclosure of the implications and probable consequences of the surgery was made by the doctor in terms that the minor could fully understand. The court said that age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents were all factors to be considered.

Under the rationale of the *Smith* case, voluntary sterilization might be permitted without parental consent even if the minor were not technically emancipated, so long as he or she were old enough and intelligent enough to understand the nature and consequences of the operation. (See discussion of *Smith v. Seibly* in Laws Relating to Contraceptive Services to Minors, and in the Summary and Analysis of State Laws Relating to Voluntary Sterilization, above).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* Washington state health agency policy on family planning is contained in two documents:

- On August 3, 1967, the Washington State Board of Health adopted a policy for the Washington State Department of Health (now the Division of Health of the Department of Social and Health Services) regarding family planning programs. The policy was codified July 1, 1968, as WAC248-128-001.
- On the basis of the State Board of Health Policy, Guidelines and Minimum Requirements for Local Family Planning Program Proposals were issued by the Office of Health Services of the Division of Health. The latest revision of these Guidelines is dated January 1971.

The Board of Health policy sets forth priorities for family planning services, standards for program operation, and recommendations for local health department participation in the development of family planning services. The policy states that "family planning should be available to all people"; however, priority is assigned to women in the "high risk" categories. Outreach and follow-up are recommended as important components of family planning programs in the policy. Freedom from coercion is guaranteed to health department workers and to potential patients. Local health department person-

nel "will require training to best achieve the desired results," according to the policy; and "local health departments shall be encouraged to, and assisted in, taking a leading role in developing local family planning programs."

The Guidelines set forth requirements for applications to the state for family planning funding. Applications, according to the Guidelines, must include profiles of the area to be served and descriptions of the services to be provided.

2. *Eligibility:*¹ There are no eligibility limitations established or recommended in the Division's Guidelines; they state: "Family planning should be available to all people. . . . No patient will be denied these benefits because of inability to pay for them." All categories of adults and minors are eligible for family planning, including never-married, never-pregnant minors; parental consent is not required. Geographical eligibility criteria are not covered in the Division's policy. Patient fees are neither established nor recommended by the Division, however, local clinics may establish fee structures subject to state approval.

3. *Administration:*² The Community Services (Maternal and Child Health) unit has administrative responsibility for family planning services in the Division of Health. The following professional staff are assigned to family planning activities: the Coordinator (medical doctor), 25-50 percent time; one administrative assistant, 25-50 percent time; two public health nurses, 25-50 percent time; and one fiscal officer, 10-25 percent time.

The Division of Health carries out the following functions in support of family planning activities: consultation, training (provided through a grant to Planned Parenthood-World Population), development and distribution of public educational materials (minimal), central data processing, grants to local family planning programs, and liaison with OEO for outreach coordination.

4. *Financing:*³ The Division of Health was allocated \$171,385 of new MCH funds for FY 1971 which were federally earmarked for family planning; the total allocation to the state of nonearmarked MCH funds for FY 1971 was \$623,001. No estimate is available for expenditures of MCH funds for family planning from these allocations. The Division received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds were utilized by the Division for family planning services in that year.

5. *Voluntary Sterilization:* According to the Office of Health Services' Guidelines, cited above, "abortions, tubal ligations, and vasectomies will not be funded by the Washington State Division of Health, however, appropriate referral for these procedures may

be made when necessary and within legal limitations."

Footnotes:

1. Unless otherwise indicated, information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Washington is contained in Section 388-16-115 of the *Washington Administrative Code*, dated August 1, 1969, and in Section 58.24 and 58.52 of the *Manual of the Division of Public Assistance*. Additional family planning policy is found in Section 3.7 of the *Title IV-A State Plan of Service Programs for Families and Children*, dated January 1971. Section 388-16-115 states: "Family planning services include social services such as information, help in planning and referral; medical services for those determined to be eligible; and community planning services. . . . The basic goals of family planning services are: a) To make available to all parents the opportunity to realize maximum opportunities for their children. b) To enable parents to control the size and spacing of their families. c) To enable persons previously unable to have children of their own to do so when possible."

According to Section 58.52 of the *Manual*: "After Family Planning Services have been offered, if accepted, the caseworker will schedule additional interviews sufficient to determine that the accepted plan or method is suitable and assist the client with any problems which may be present."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Division of Public Assistance *requires* local welfare agency to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients. According to Section 3.7 of the *State Plan*, the Division "will offer, provide, and pay for family planning services."

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies and private physicians. The Division reported that "the family planning program has now been transferred under Title IV-A; but the statistics on expenditures are not yet available," and "family planning services are now being offered and provided for all interested current public assistance recipients." The Division also reported that there is a standard, statewide reimbursement rate for medi-

cal family planning procedures.² The reimbursement rates are as follows: Initial medical examination, \$12.00 plus laboratory work; Annual medical examination, up to \$12.00 plus laboratory work; IUD insertion, \$15.00; One cycle of oral contraceptives, \$2.40 (average); Cytologic study, up to \$18.00.

The Division reported that it has contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance, and General Assistance recipients, are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance are eligible for referral services only.

There are no additional stated limitations which affect the provision of services to adults or minors. Section 388-16-115 of the *Administrative Code* states: "Family planning information and services must be available to all appropriate individuals in the AFDC program including all women of child bearing age."

4. *Administration:*⁴ The Office of Social Services and two of its units, the Family and Children's Services Section and the Adult Services Section, are responsible for the administration of the welfare family planning program. One Program Specialist spends 25-50 percent of her time, and one Family Services Specialist spends from 10-25 percent of his time on family planning activities. Family planning activities include training of welfare staff, the develop-

ment and distribution of educational material, and the development of local family planning clinics as well as leadership on state Family Planning Council.

5. *Financing:*⁵ The Department of Social and Health Services received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Division of Public Assistance has a written policy on sterilization. Sec-58.52 of the *Manual* provides that "if a permanent medical procedure such as sterilization is performed, social service will be offered as for other major medical procedure." The CFPPD survey indicated that the Division *requires referral* for and the *purchase* of sterilization procedures by local welfare agencies for eligible public assistance recipients who wish them.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Washington Medicaid program, family planning services are "Provided. Including drugs, supplies, and devices. No limitations, but services must be under supervision of a physician... Reimbursement on basis of fee schedule." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Laws and Policies section of this report.)
3. As reported in CFPPD survey unless otherwise indicated.
4. Ibid.
5. Ibid.

West Virginia

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs*: In 1966 West Virginia by legislation created a Family Planning and Child-spacing Section under the Maternal and Child Health Division of the State Department of Health. This section is authorized to provide "printed material, guidance, advice, financial assistance, appliances, devices, drugs, approved methods, and medicines" to local boards of health requesting any of these for use in the operation of family planning and child-spacing clinics to the extent that funds are appropriated by the legislature and there are any available federal funds. W. Va. Code Ann. § 16-2B-1 (1970 Supp.). Local boards of health are authorized to establish and operate family planning child-spacing clinics under the supervision of licensed physicians. These clinics are authorized to disseminate information, conduct medical examinations and distribute family planning and child-spacing appliances, devices, drugs, approved methods and medications without charge to "indigent and medically indigent persons" ¹ on request and with the approval of the physician supervising the clinic. Sterilization and abortion are excluded from the services offered. § 16-2B-2.

Employees of the State Department of Health and the Department of Welfare are instructed to advise the indigent and medically indigent persons with whom they work of the availability of these family planning services. No person is required to accept or practice family planning as a condition of receiving government benefits or public services. Section 16-2B-3.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives*: None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives*: None found.

West Virginia has a statute which prohibits publishing any advertisement "concerning" venereal disease or calling attention to persons or places where information, treatment or advice on venereal disease may be obtained. W. Va. Code Ann. § 16-4-25 (1967 Supp.). An exception in the statute exempts legitimate public notices issued under the direction

of the State Department of Health, and literature sent out either by the Department of Health or the United States Public Health Service.

4. *Laws Relating to Contraceptive Services to Minors*: The age of majority is 18. Chapter 61, Acts of the Legislature, Regular Session, 1972.

Any licensed physician may examine, diagnose, or treat any minor with his or her consent for any venereal disease without the knowledge or consent of the minor's parent or guardian. The physician incurs no civil or criminal liability in connection therewith except for negligence or wilful injury. W. Va. Code Ann. § 16-4-10 (1972 Cum. Supp.).

In *Browning v. Hoffman*, 90 W. Va. 568, 111 S.E. 492 (1922), a physician was held to have been justified in amputating a boy's leg in an emergency where an unsuccessful effort to find the parents had been made. The court based its decision on the negligence of the parents who were not close by and the futility of notice to them had it been given.

We have found no cases indicating whether West Virginia courts follow the general pattern of permitting medical treatment for minors without parental consent where the minors are "emancipated," or whether West Virginia courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors." However, West Virginia courts have recognized that a minor can be emancipated from parental control and the "[E]mancipation may be oral or written, may be proven by circumstantial evidence or may be implied." See *Trapnell v. Conklin*, 37 W. Va. 242, 16 S.E. 570 (1892); *Wiese v. Yokum*, 62 W. Va. 550, 59 S.E. 514 (1907).

We have seen that local boards of health are authorized to provide birth control services and supplies to indigent and medically indigent persons upon request (See "Laws Establishing Family Planning Programs," above). The Department of Health *Procedures Manual* states that "services shall be available without regard to . . . age, maternity, or marital status." The Department of Welfare permits services to minors without parental consent except where required by individual doctors (See "Health and Welfare Policies," "Eligibility," below.)

Footnote:

1. Before a 1969 amendment thus liberalized the statute, eligibility for family planning service was restricted to persons who were married and living with their spouses. Section 16-2B-2.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

Bishop v. Byrne, 265 F. Supp. 460 (S.D. W. Va. 1967), was an action brought in the United States District Court by a husband and wife against a surgeon for alleged negligence and breach of warranty in the performance of a voluntary sterilization operation on the wife. Mrs. Bishop had a healthy baby two years after the surgery. Applying West Virginia law, the court denied defendant's motions for dismissal and summary judgment. The court held that a jury could find that the doctor had undertaken to perform a sterilization operation and had failed to do so, in which case the plaintiff would be entitled to recover for all pain and suffering, mental and physical, together with loss of services and any other loss or damages proximately resulting from the negligence. The court assumed that voluntary sterilization is legal in West Virginia.

West Virginia has a statute which provides for the compulsory sterilization of persons afflicted with certain incurable conditions. This statute contains the following provision:

Nothing in this article shall be construed to authorize the operation of castration nor the removal of sound organs from the body; but this provision shall not be construed so as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this State, by a physician or surgeon licensed by this State, in such a way as may incidentally involve the nullification or destruction of the reproductive functions. W. Va. Code Ann. § 16-10-6 (1966).

In other words, if an operation such as a hysterectomy is performed for medical reasons on a person who is otherwise subject to the provisions of the compulsory sterilization law, the procedures prescribed in that law need not be followed although the operation may involve the removal of sound organs from the body.

We have seen that in West Virginia local boards of health are authorized to establish family planning clinics to provide birth control services to the indigent (See Laws Establishing Family Planning Programs, above). Sterilization is declared to be a *non-approved* method of family planning within the intent of this statute and is expressly excluded from the program. W. Va. Code Ann. § 16-2B-2 (1970 Supp.)

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy*: The current State Department of Health policy on family planning consists of an *Operational Procedures Manual for Family Planning and Child Spacing Clinics*, dated August, 1970. The *Manual* sets forth general policies on eligibility, patient fees, confidentiality, guarantees against discrimination, requirements for clinic organization and staffing, reports, staff training and orientation, and child care services. A list of state health agency services to local health agencies is set forth in the *Manual*, including the provision without charge of: contraceptive supplies, clinic supplies, equipment, additional part-time staff, financial support for hospital and emergency outpatient care incidental to family planning services, lab tests, transportation services, consultation regarding program design and standards, rental of clinic space and record keeping forms. The *Manual* also sets forth detailed administrative procedures as well as procedures for clinic services and routine. Contraindications and precautions for various contraceptive methods are presented.

In an opinion of the West Virginia Attorney General's Office, dated June 16, 1971, prepared in response to a request from the State Director of Health, the Assistant Attorney General stated that in view of the Public Health Laws of West Virginia (Section 16-2B-2): "It is our opinion that the supervision of all family planning and child spacing clinics in the state, which are financed by state and Federal funds is within the sole jurisdiction of the state health department. . . ."

2. *Eligibility*: The Department of Health recommends that any patient whom the local clinic staff determines can pay for family planning services "without hardship" be directed to a private physician, according to the CFPPD survey. The *Procedures Manual* states that "services shall be available without regard to race, age, religion, nationality, maternity, or marital status." However, under policy established by the Department as reported in the CFPPD survey, all adults are eligible, but unmarried minors must have parental consent. Family planning services are available to West Virginia residents only, according to the *Procedures Manual*, which adds: "No charge shall be made to any person for services rendered in this family planning program. . . ."

3. *Administration*:¹ The Division of Maternal and Child Health has administrative responsibility for family planning services in the Department of Health. The statewide family planning project is a special program located in the Division. The following full-time staff are assigned to this project: the Project Director, one obstetrician-gynecologist, two

health educators, one social worker, one licensed practical nurse, two secretaries, one office clerk, one warehouse man, and one mobile unit operator. Two obstetric-gynecology consultants are employed less than 10 percent time on this staff. Other Department of Health employees participate in planning and implementation of family planning services as they affect their respective units. The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment, or other materials to local family planning programs; grants or contracts to local family planning programs for support of services; and direct technical assistance to local family planning programs, including staffing and establishment of clinics.

4. *Financing*:² \$108,366 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$515,684; an estimated \$40,065 of these funds were spent for family planning services. The Department of Health received no specific appropriation for family planning services from the state legislature in FY 1971; \$134,000 of state funds were utilized to match DHEW National Center for Family Planning Services grant of \$392,400, in one family planning service project, and \$40,000 of state funds was used for two MIC projects in FY 1971.

5. *Voluntary Sterilization*:³ State Department of Health policy rules out voluntary sterilization as an "acceptable means for family planning" (See Laws on Sterilization, above).

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.
3. As reported in CFPPD survey.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in West Virginia is contained in Sections 8000 through 8050 of the *Social Services Manual* of the Department of Welfare, dated July 1969. These sections define family planning, list the services that the agency provides, provide guidelines to welfare workers in offering family planning services and contain a statement on program purposes; these are as follows:

The purposes of Family Planning Services are to provide individuals and/or families with the opportunities to determine the number and spacing of their children and to improve the understanding of family life and human sexuality in order to strengthen the integrity of the family, to protect and promote the physical and emotional health of family members in general and of mothers and children in particular, to reduce maternal and infant mortality and morbidity, to decrease the incidence of mental retardation and congenital defects, to decrease the number of premature births, and to reduce the incidence of out-of-wedlock births.

The policy also states: "Unwanted children often contribute to family breakdown and perpetuation of ill health, poverty and neglect. They contribute also to the continuing population explosion."

2. *Referral and Purchase Provisions*:¹ Under the policy, the State Department of Public Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services and to *purchase* medical services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics and private physicians. Health departments and voluntary agencies are not authorized to receive reimbursement under the policy. The Department reported that there is a standard statewide reimbursement rate for medical family planning procedures which is contained in an "Unpublished fee schedule—usual and customary charges as billed."² The policy, however, provides in Section 8050 that "in order for the agency to pay for any contraceptive device, the client *must* see a physician who will then write the prescription for the particular method decided upon. If the client is paying for the contraceptive device himself consultation with a physician is not necessary for the purchase of the condom, chemical methods, sponge and foam, and douche powder." There is no information as to whether the Department has contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance and all General Assistance recipients are eligible for medical family planning services. Applicants, potential recipients, and past recipients of such assistance and residents of low-income areas are eligible for counseling and referral services only. There are no additional limitations that affect the provision of services to adults or minors. The Department reported, however, that "some doctors require consent of parents."

4. *Administration*:⁴ The Division of Social Services in the State Department of Public Welfare apparently has administrative responsibility for the welfare family planning program. The Director of the division spends less than 10 percent of her time on family planning activities. Family planning activities of the division include the training of local

welfare staff and the development and distribution of public educational materials.

5. *Financing*:⁵ The Department of Welfare received no specific appropriation for family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization*: The Department of Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.

2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the West Virginia Medicaid program, family planning services are "Provided. Under direction of physician. Including drugs, supplies and devices. . . . Reimbursement to physician on basis of usual and customary charges up to fee guide maximum allowances." The extent of utilization of the Medicaid program for family planning services is unknown. For additional information on Medicaid see Federal Laws and Policies Section of this report.

3. As reported in CFPPD survey, unless otherwise indicated.

4. Ibid.

5. Ibid.

Wisconsin

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* There is no law establishing a state family planning program in Wisconsin.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* Under Wisconsin law, the sale of contraceptives may be made only by registered pharmacists and licensed physicians or surgeons.¹ Wis. Stat. § 450.11 (4) (1969).²

This same statute makes it a misdemeanor to sell or dispose of contraceptives "to or for any unmarried person." Section 450.11 (4). A recent United States Supreme Court decision holding unconstitutional a similar provision in a Massachusetts statute casts doubt on the validity of this section.³

Also prohibited is the manufacture, purchase, rental or possession of vending machines designed for contraceptives. Section 450.11 (3).

In *State v. Arnold*, 217 Wisc. 340, 258 N.W. 843 (1935) the Wisconsin Supreme Court construed this statute and upheld its constitutionality. The defendant was a gas station owner with a vending machine for condoms in the men's washroom. The vending machine was labeled "sold only for the prevention of disease" and "minors are prohibited to operate machine." The defendant contended that the devices were not sold to "prevent pregnancy" (as is proscribed by the statute), but to prevent disease. He also contended that the statute was unconstitutional because it discriminated between married and unmarried persons. The court ruled that the statute applied to "articles solely capable of use as contraceptives . . . or appropriate to that use and sold with the intention or purpose that they be so used or upon the representation that they are effective for that purpose." Thus, sale of condoms in a public toilet was held sufficient to infer that the purpose of the sale was contraception and not merely the prevention of disease. As to the constitutional question, it was held that defendant could not question the discrimination between married and unmarried persons since he was not affected by it.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* The Wisconsin statute on "indecent articles" makes it a misdemeanor to ad-

vertise or display contraceptives. Wis. Stat. § 450.11 (2) (1969).

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority for most purposes is 18. Wis. Laws 1971, ch. 213 (effective March 23, 1972).⁴

As discussed above under Laws and Court Decisions Relating to Sale and Distribution of Contraceptives, the validity of Wisconsin's restriction on the distribution of contraceptives to unmarried persons found in § 450.11 (4) is now open to question. If § 450.11 (4) is held unconstitutional, then unmarried persons may receive contraceptive services on the same basis as married persons in Wisconsin. This of course would affect minors, most of whom are unmarried.

Should this contingency occur, the question of emancipation would become relevant. Though we have found no cases involving medical treatment of emancipated minors, Wisconsin courts do view emancipation as an extinguishment of parental rights and duties (see cases discussed below) and thus presumably would follow the general pattern of permitting an emancipated minor to consent to his own medical care without the necessity of parental consent.

A minor who is emancipated has the same status as one who has reached majority at least in relation to his parents. *Groh v. W.O. Krahn, Inc.*, 223 Wis. 662, 271 N.W. 374 (1937). Marriage emancipates a minor. *La Crosse County v. Vernon County*, 233 Wis. 664, 209 N.W. 279 (1940).

The age of consent for marriage is 18 for males and 16 for females. Wis. Stat. § 245.02 (1) (1972 Cum. Supp.). Males younger than 18 years⁵ and females between 16 and 18 years need written parental consent in order to be issued a marriage license. § 245.02 (2), as amended by Wis. Laws 1971, ch. 213. Section 245.21 provides that all marriages contracted in violation of these requirements "shall be void."⁶

Emancipation may also occur by operation of law;⁷ by voluntary surrender of the parental right to the earnings of a child by express agreement; or by implied agreement where the conduct of the parents after the child leaves home is wholly inconsistent with the assertion of the parental right. *Patek v. Plankinton Packing Co.*, 179 Wis. 442, 190 N.W. 920 (1922). Emancipation may be total or partial and limited to certain purposes. *Niesen v. Niesen*, 38

Wis. 2d 599, 157 N.W. 2d 660 (1968).

A child may be emancipated for the balance of its minority or for a shorter period, and such emancipation may be conditional or unconditional. *Wadoz v. United National Indemnity Co.*, 274 Wis. 383, 80 N.W. 2d 262 (1957).

Some examples of how the Wisconsin courts view emancipation in particular fact situations follow:

In *Prelipp v. Prelipp*, 203 Wis. 488, 234 N.W. 730 (1931) the court held that even when a minor lives at home and works for his father, an implied emancipation may be found from a promise on the part of the father to pay his minor son wages for his services during the period of minority. (This case involved a minor suing one standing in loco parentis to him for wages earned during minority under an alleged contract of hire.⁸ See also *Curt v. Industrial Commission*, 275 N.W. 447 (1937).)

In *Groh v. W.O. Krahn, Inc.*, *supra*, the court found that a 20-year-old minor was emancipated even though he lived at home, because he paid for his room and board, did not account for his earnings, came and went as he pleased and was expected to provide for himself. (This finding of emancipation enabled the son to maintain an action for injuries as a guest in a car driven by his father).

In *Patek v. Plankinton Packing Co.*, *supra*, a minor who left home after an argument with his parents over his right to keep his earnings was held emancipated even though he later resumed contact with his mother. The father had attempted to collect the son's wages from the son's employer on the grounds that the son was unemancipated, but the court found an implied emancipation from the conduct of the father in expecting his son to provide for himself and not account for his earnings.

In *Caskey v. Peterson*, 220 Wis. 690, 263 N.W. 658 (1935), a minor of 19 who lived away from home and maintained himself by working was found to be emancipated. Though there was no formal emancipation, oral expressions of intent to emancipate or abandonment by the father were held to be sufficient for emancipation. See also *Kidd v. Joint School Dist. No. 2*, 194 Wis. 353, 216 N.W. 499 (1927) where a boy of 16 was held emancipated after he left home with his father's approval, and found a place where he could earn his own living and attend high school.

In *Tande v. Vernon County*, 226 Wis. 602, 276 N.W. 359 (1957) the court held that a minor still in high school who had no earnings other than the small amount earned during his school vacation (but who could use the money as he pleased) was not, as a matter of law, emancipated.⁹

We have found no cases indicating whether Wisconsin courts would accept the "mature minor" doctrine discussed in the Summary and Analysis of State

Laws Relating to Contraceptive Services to Minors or whether they follow the general pattern of permitting medical treatment for minors without parental consent in emergencies.

The State Department of Public Welfare has authority to consent to emergency surgery for any child in its legal custody if reasonable effort has been made to secure the consent of the child's parent or guardian. Wis. Stat. § 48.48 (1972 Cum. Supp.).

The Attorney General has stated that the State Board of Control (which has the power to govern and maintain the Wisconsin industrial school for boys and girls, and the state public schools) may consent to an emergency operation to save the life of a child committed to the state industrial school if parental consent cannot be secured. 22 Op. Atty. Gen. 763 (1933).

Section 48.13 of Wisconsin's Statutes gives the juvenile court jurisdiction over children alleged to be "neglected," i.e., children who are "without necessary subsistence, education or other care necessary for . . . [their] health, morals or well-being. . . ." Under § 48.395, "The juvenile court may authorize medical services including surgical procedures when needed if the court determines that reasonable cause exists for such services and that the minor is within the jurisdiction of the court and consents."

Footnotes:

1. Note that this limitation in § 450.11 (4) refers only to "sale" whereas the limitation in § 450.11 (4) relating to the unmarried refers to "sell or dispose."
2. Before 1969, section 450.11 was numbered 151.15.
3. *Eisenstadt v. Baird*, 40 U.S. Law Week 4303 (March 21, 1972). See Massachusetts Profile for discussion of case.
4. The law is entitled "An Act to amend 66.054 (13), 238.01, 238.05 and 247.02 (8) of the statutes, relating to lowering the age of majority from 21 years of age to 18 years." In addition to the four statutory sections mentioned in the title, § 5 of the law also amends many specifically enumerated sections in the Wisconsin statutes by changing the term "21 years" to "18 years." Among those enumerated sections are § 990.01 (3) and (20) which define "minor" and "adult" when used in the statutes.
5. Wis. Laws 1971, ch. 213 lowered this to 18; formerly it was 21. The requirement for parental consent for males younger than 18 seems anomalous in light of § 245.21 which declares a marriage involving a male younger than 18 void.
6. Except as provided in § 245.22 which states that no marriage "shall be void by reason of want of authority or jurisdiction in the officiating person solemnizing such marriage. . . ." and section 245.23 which states that no marriage shall be void by reason of immaterial irregularity of form in the application for a license, or the license itself; incompetency of the witness; etc. "The parties to any such marriage declared void under § 245.02 . . . may come at any time, validate such marriage by complying with the requirements of § 245.02. . . ." Wis. Stat. § 245.21 (1972 Cum. Supp.)

In a case decided in 1890 under a statute declaring every male of 18 and every female of 15 capable of contracting marriage, the court held that a marriage entered into by persons below the age of consent and above the age of seven years and capable of consummating the marriage,

is voidable and not void. *Eliot v. Eliot*, 77 Wis. 634, 46 N.W. 806 (1890). "However, a recent law review article states that, no case has considered the problem since passage of § 245.002(3) [now § 245.21] which, it could be argued, was intended to change the status of the underage marriage from voidable to void as is specifically stated by the statute." Foley, "The Voidable Void Marriage in Wisconsin," 49 Marquette L.R. 751, 760 (1966).

7. For example, by such ill treatment or abuse by the parent that the child is practically driven away from home; by the parent leading an immoral and dissolute life so that it would be improper and unsafe for the child to live under such surroundings; by the parents failing to give proper support to a child when they are able to do so. Wisconsin has codified this latter provision to some extent in Wis. Stat. § 48.99 (1957): "During any time when a parent of a minor neglects or refuses to provide for his support . . . , the earnings of such a minor shall be his sole property as against such parent or any creditor of such parent."
8. While the court denied recovery on the ground that the emancipation and the contract for services were not sufficiently established, it inferentially held that plaintiff would have won except for a failure of proof.
9. See also *Niesen v. Niesen*, 38 Wis. 2d 599, 157 N.W. 2d 660 (1968) where the court held that when the mother retained the rights of custody and control of her two sons after a divorce decree, the father no longer could emancipate the sons. This case involved the father's attempt to stop paying support for his two sons aged 17 and 18 on the grounds that they became emancipated when they legally took the surname of their stepfather.

B. Laws Relating to Voluntary Sterilization

An opinion of the Wisconsin Attorney General with regard to voluntary contraceptive sterilization states:

A doctor performing a sterilization operation, such as salpingectomy or vasectomy, at the voluntary rational consent of a patient, is not committing a crime under Wisconsin law. Letter from Attorney General Bronson C. LaFollette to Thomas W. Tormey, Jr., M.D. November 25, 1968.

In this opinion, the Attorney General specifically states that the Wisconsin mayhem statute does not apply to voluntary sterilization.

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Wisconsin Division of Health has no official written policy on family planning.

2. *Eligibility:*¹ Eligibility requirements for family planning services, as well as patient fees, are determined by local health agencies.

3. *Administration:*² The Maternal and Child Health Section, Bureau of Community Health Services, has administrative responsibility for family planning services in the Division of Health, Wisconsin Department of Health and Social Services.

Staff assigned to family planning activities include: the Director of Community Health Services, less than 10 percent time; the MCH Section Chief, 25–50 percent time; two full-time public health educators; and one full-time public health nurse.

The Division of Health performs the following functions in support of family planning activities: consultation, training, development and distribution of public educational materials, and grants or contracts to local family planning programs for support of services.

4. *Financing:*³ \$144,294 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$852,805. An estimated \$64,575 of these funds were spent for family planning services. The Division of Health had no specific appropriation for family planning services from the state legislature in FY 1971.

No other state funds were utilized by the state health agency for family planning.

5. *Voluntary Sterilization:* The Division of Health has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Ibid., except that figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Wisconsin is contained in Section 3.7 of the *Title IV-A State Plan of Service Programs for Families and Children*, dated May 1969. Section 3.7 reads as follows:

Wisconsin Statutes limit the providing of family planning services to physicians and for married couples only. Agreement was reached by HEW and Congress that Wisconsin's Statute which is contrary to federal legislation could not cause the State to be out of compliance and also that the federal legislation would not be enforced.

Additional family planning policy is contained in *Family Planning Services for Married Persons* which the Division of Family Services indicated in the CFPPD survey are "guidelines for developing procedural manual instructions in respect to family planning services to married persons within Wisconsin State Statutes." The guidelines are dated August 1971, but no manual reference number has been issued. According to the guidelines: "The Division of

Family Services advocates and actively supports family planning services compatible with the goal of strengthening family life and preservation of the family's right to freedom of choice based on each individual family's own convictions and values."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Department *authorizes* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. Local welfare agencies are also authorized to *purchase* medical services for these recipients.

The policy authorizes reimbursements to hospital outpatient clinics, health departments, voluntary agencies and private physicians, "if billed by a licensed physician or surgeon or a registered pharmacist." There is no single, standard, statewide reimbursement rate for medical family planning procedures.² The Division has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning service. Applicants, past recipients and potential recipients of such assistance and residents of low-income areas are eligible for referral services only. The Division does not fund or administer a General Assistance program.

Only married adults and those minors that are married are eligible for family planning services.

4. *Administration:*⁴ The Division of Family Services in the Wisconsin Department of Health and Social

Services has administrative responsibility for the welfare family planning program. One Social Service Planning Specialist and two staff Development Specialists spend less than 10 percent of their time on family planning. Plans are currently being developed for the training of local welfare staff and the development and distribution of educational materials.

5. *Financing:*⁵ The Department of Health and Social Services received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Division of Family Services has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Wisconsin Medicaid program, family planning services are "Provided. Professional services plus drugs, supplies, and devices. For medically needy persons, limited to professional services and drugs. . . . Reimbursement of professional services on basis of usual, customary, and reasonable charges, not in excess of maximums established by Medical Section of State Agency; of drugs and devices, on basis of usual charge to general public." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey, unless otherwise indicated.
4. Ibid.
5. Ibid.

Wyoming

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:*

In 1969, Wyoming passed a law authorizing the dissemination of family planning and birth control information and services by the Departments of Public Health and Public Welfare and their local subdivisions. Wyo. Stat. Ann. §§ 35-508 to 35-513 (1971 Supp.). These departments are "empowered to provide and pay for family planning and birth control information and services . . . for every person who might have interest in, and benefit from, such information and services." Medical services must be performed by a licensed physician. Family planning services may include interviews, distribution of literature, referrals to physicians for consultations, examinations, tests, medical treatment and prescriptions, and, to the extent prescribed, the distribution of charts, drugs, medicines, contraceptive devices, etc. Any person may refuse to accept family planning services without affecting his or her right to receive public assistance or other public benefits. The service must be provided in a language the applicant can understand, if that language is not English.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* In 1969, Wyoming amended its statute relating to the "distribution and sale of obscene, lewd or indecent articles" so as to delete reference to articles for preventing conception.¹ Thus, there is now no state law specifically restricting or regulating the sale or distribution of contraceptive drugs or appliances.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found. Wyoming has a statute which prohibits any advertisement or writing which refers to persons from whom, places at which, or means by which venereal disease treatment or cure may be obtained; the statute also prohibits referral to any medicine or device that may be used for the prevention of venereal diseases. Wyo. Stat. Ann. § 35-180 (1959).

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. However, under a law adopted in 1971 the age of majority for all purposes will be reduced to 18 on January 1, 1973, if the voters of Wyoming adopt a constitutional amendment at the 1972 general election. Wyo.

Stat. Ann. § 14-1.1 (Cum. Supp. 1971).

Also subject to approval by referendum is the new marriage statute, which provides that at the time of marriage the male must be 16 or older and the female 15 or older. When either party is younger than 18, no marriage license shall be granted without the consent of the father, if living; if not, then of the mother or guardian. Wyo. Stat. Ann. §§ 20-2, 20-3 (as amended by Laws 1971, Chapter 247).

We have found no cases indicating whether Wyoming courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies and where the minors are "emancipated" or whether Wyoming courts would accept the "mature minor doctrine" described in the "Summary and Analysis of State Laws Relating to Contraceptive Services to Minors."

The juvenile court may authorize and consent to emergency medical, surgical or dental examination or treatment of a child taken into custody either before or after the filing of a petition alleging that the child is neglected, delinquent or in need of supervision. Wyo. Stat. Ann. § 14-115.21 (Cum. Supp. 1971).

We have seen that the Departments of Public Health and Public Welfare are empowered by statute to provide and pay for family planning and birth control information and services performed by a licensed physician "for every person" who might want and benefit from them (See "Laws Establishing Family Planning Programs," above). This is apparently interpreted by the welfare department as including minors on their own consent since the welfare department does *not* require parental consent for provision of family planning services to minors (See "Welfare Policy," "Eligibility," below).

Footnote:

1. In 1971, the entire statute was repealed and replaced by a law applicable only to "obscene material . . . intended for visual or auditory perception." Wyo. Stat. Ann. § 6-105 et seq. (Cum. Supp. 1971). Former §§ 6-103 and 6-104 were repealed by Laws 1971, ch. 138, § 5.

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

We have seen that the departments of public health and welfare are empowered by statute to provide and pay for family planning information and services performed by a licensed physician to "every person who might want and benefit from these services" (See Laws Establishing Family Planning Programs, above). It is not clear whether "services" encompassed include voluntary sterilization.

The CFPPD survey indicates that the Division of Public Assistance leaves the question of referral for sterilization procedures to the option of local welfare agencies. It authorizes local welfare agencies to pay for sterilization procedures. Voluntary sterilization procedures in Wyoming are covered by the Medicaid program (See Welfare Policy, Referral and Purchase, and Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The Division of Health and Medical Services, Wyoming Department of Health and Social Services has no official written policy on family planning.

2. *Eligibility:*¹ Financial, social and geographical eligibility requirements, as well as patient fees, are determined by local health agencies. The Division of Health and Medical Services recommends that family planning services be directed to low or marginal income groups.

3. *Administration:*² Administrative responsibility for family planning is not assigned to a specific subunit of the Division of Health and Medical Services. Staff assigned to family planning activities include the Administrator, Department of Health and Social Services, less than 10 percent time; and the MCH nursing consultant, less than 10 percent time.

The Division performs consulting and training functions in support of family planning activities. A minimal amount of money is available for grants or contracts to local family planning programs for support of services, according to the Division.

4. *Financing:*³ \$7,815 of new MCH funds were allocated to the state in FY 1971 which were federally earmarked for family planning. All of these funds were obligated for family planning activities. The total allocation to the state of nonearmarked MCH funds for FY 1971 was \$173,908. None of these funds were spent for family planning services. The Division of Health and Medical Services received no specific appropriation for family planning from the state legislature in FY 1971. No other state funds are utilized by the state health agency for family planning services.

5. *Voluntary Sterilization:* The Division of Health and Medical Services has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the state health agency in the CFPPD survey.
2. Ibid.
3. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy:* Welfare family planning policy in Wyoming is contained in Volume III, Sections 430 and 431 of the *Manual* of the Division of Public Assistance and Social Services (D-PASS) in the State Department of Health and Social Services. In addition, Volume I, Section 230 of the *Manual* contains the Wyoming law pertaining to family planning and birth control. Section 430 of the *Manual* states: "Family planning services are directly related to alleviating personal and family problems that may be attributed to the size of the family and spacing of the children, or potential pregnancies which may prove detrimental to the health of the mother and the well-being of the family. Family planning is one part of the total D-PASS health and social services program and is much broader than birth control. Primarily, it is the promotion of responsible parenthood."

2. *Referral and Purchase Provisions:*¹ Under the policy, the Division of Public Assistance and Social Services *recommends* that local welfare agencies *refer* eligible public assistance recipients to medical family planning services. The Division reported that "county departments may make payment for medical services if they have sufficient local funds." The Division further reported that "The only medical [family planning] services available statewide are those covered by the Title XIX program." This is limited to office calls and surgical procedures for the purpose of sterilization for both males and females.² The Division has no contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility:*³ All current recipients of federally-aided assistance are eligible for medical family planning services. Applicants, past recipients, and potential recipients of such assistance, General Assistance recipients and residents of low-income areas are eligible for referral services only.

There are no additional limitations that affect the provision of services to adults or minors. Under current welfare policy, consent is *not* required for the provision of services to minors. Wyoming law is quoted in Section 230 of the *Manual*, as follows:

The Wyoming department of public health and the Wyoming department of public welfare and their local subdivisions are hereby empowered to provide and pay for

family planning and birth control information and services, provided however, any medical service shall be performed by a licensed physician, for every person who might have interest in, and benefit from, such information and services.

4. *Administration:*⁴ The Division of Public Assistance and Social Services in the Wyoming Department of Health and Social Services has responsibility for the welfare family planning program. One Family Services Specialist spends from 10–25 percent of his or her time in family planning activities. Family planning activities of the Division include the training of local welfare staff and the development and distribution of public educational materials.

5. *Financing:*⁵ The Department of Health and Social Services received no specific appropriation for welfare family planning services from the state legislature in fiscal year 1971.

6. *Voluntary Sterilization:* The Division of Public Assistance and Social Services has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Division leaves the question of referral for sterilization procedures to the option of local welfare agencies. Local welfare agencies, how-

ever, are authorized to pay for sterilization procedures. As noted above, voluntary sterilization procedures are covered by the Medicaid program.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the state welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Wyoming Medicaid program, family planning services are "Not provided. [Payment for physicians' services connected with family planning covered by the program's basic physicians' services provisions. Payment for required devices and/or prescription medications are provided to public assistance recipients through the State/county non-federally aided 'Minimum Medical Program.']" However, this publication is based on data as of January 1970 and the Wyoming Medicaid program may have been modified since that date. The 1970 City University of New York study reported that \$10,000 was expended for medical family planning services by the Wyoming Medicaid program in fiscal year 1969. Projected fiscal year 1970 expenditures for medical services were \$15,000. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey unless otherwise indicated.
4. Ibid.
5. Ibid.

District of Columbia

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* A regulation states that birth control information, services and devices are to be provided at no cost in the District of Columbia's health facilities "without regard to the age or marital status of the patient." D.C. Reg. No. 71-27 (1971).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21.

Birth control information, services and devices must be provided by the health facilities operated by the District of Columbia, and *may* be provided by any qualified person or institution, without regard to the age or marital status of the patient or the consent of the patient's parent or guardian. D.C. Reg. 71-27 (1971). Both the Health and Welfare Departments have policies that all minors are eligible for services without parental consent (See Health and Welfare Policies, Eligibility, below).

A minor can consent to treatment for venereal disease at any public health facility. The Director of Public Health or his authorized agent is required to exercise reasonable diligence in locating a parent, or person standing in loco parentis to the minor, and notifying him that the minor is affected with venereal disease. D.C. Code Encycl. Ann. § 6-119j-1 (1966).

B. Laws Relating to Voluntary Sterilization

There is no statute or court decision which restricts the availability of voluntary sterilization of competent persons by licensed physicians; the applicable law is the same as for other surgical procedures.

We have seen that the District of Columbia has a regulation which provides that birth control services must be furnished by the District of Columbia's health facilities without regard to the age or marital status of the patient or the consent of the patient's parent or guardian, D.C. Reg. No. 71-27 (1971). (See Laws Establishing Family Planning Programs, above). It is not clear whether voluntary sterilization

is included as a "birth control service" under this regulation. However, the CFPPD survey indicates that the Social Services Administration authorizes referral for sterilization procedures for those who wish them. (See Welfare Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current District health policy on family planning consists of a *Policies and Procedures Manual*, dated July 1966, and a "Regulation Governing the Provision of Contraceptive Information Services and Devices to Minors," approved August 1971.

The *Manual* sets forth the purposes and objectives of the District's birth control program and assigns responsibility for the program to the Bureau of Maternal and Child Health (see Section 3, below, regarding current administration of the program.) Eligibility standards for the birth control program are described. The *Manual* specifies services to be offered, including birth control information and supplies, and specifies that no charges for services will be made. Various birth control methods are described, and the right of the patient to make a free choice among methods within limitations is guaranteed. Procedures for referrals from the District's welfare agency are set forth. The activities and functions of the Joint Departmental Committee on Birth Control (now the Metropolitan Interagency Council on Family Planning), which includes representatives of the District's health and welfare agencies and of Planned Parenthood of Metropolitan Washington, D.C., are presented.

The "Regulation" cited above states that "birth control information, services and devices shall be provided by the health facilities operated by the District of Columbia, and may be provided by any qualified person or institution without regard to the age or marital status of the patient or the consent of the patient's parent or guardian." The "Regulation" provides that such services shall be provided without charge to the patient "unless voluntary payments [contributions] are made." No other public benefits shall be conditional upon the acceptance of birth control information services and devices according to the "Regulation."

2. *Eligibility:* Under the District's recommended

family planning policy, as reported in the CFPPD survey, all categories of adults and minors, without parental consent or age requirements, are eligible for family planning services. However, according to the *Manual* cited above, since facilities and funds are limited, priorities for eligibility are assigned according to factors of income, fertility, medical risks and marital status. Currently acceptable categories, according to the *Manual*, are: patients in the maternity clinics of the Bureau of Maternal and Child Health, in hospitals under contract to the District of Columbia, or in the District of Columbia General Hospital; mothers who are delivered at D.C. General Hospital or contract hospitals; women referred by the Department of Public Welfare (restricted to applicants under the Aid to Families with Dependent Children program and trainees and their families enrolled in the work and training opportunity program administered by the Public Welfare Department); and women who are medical referrals. No charge is made for family planning services under District policy. As reported in the CFPPD survey, "it is requested that participants be domiciled in the District of Columbia, however, legal residence is not imposed."

3. *Administration*:¹ The Community Health Services Administration's Directorate for Clinical Services has administrative responsibility for the District of Columbia birth control program as of October 3, 1971. Professional staff assigned to family planning activities include 14 physicians (one full-time; seven, 10-25 percent time; and six, 25-50 percent time); 15 clinical nurses (two full-time; seven, 10-25 percent time; and six, 25-50 percent time); one licensed practical nurse, 25-50 percent time; and 17 clinic aides (two full-time; eight, 10-25 percent time; and seven, 25-50 percent time.)

The District health agency performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; purchase or provision of supplies, equipment or other materials to local family planning programs; and provision of family planning medical and informational services. Selected staff of the Community Health Services Administration are presently participating as members of the Metropolitan InterAgency Council on Family Planning.

4. *Financing*:² In FY 1971 the District received and obligated \$12,737 of new MCH funds which were federally earmarked for family planning. The total allocation to the District of non earmarked MCH funds for FY 1971 was \$247,944. We have no information as to what proportion of these funds was spent for family planning. The District health agency received a total of \$663,902 for family planning from the U.S. Congress and from the City Council for FY 1971.

5. *Voluntary Sterilization*: "Sterilizations are performed in accordance with the accepted standards of medical practice," according to the "Regulations" cited above.

Footnotes:

1. Information contained in this section was reported by the District health agency in the CFPPD survey.
2. Information contained in this section was reported by the state health agency in the CFPPD survey except that figures on allocations of MCH formula grant funds to the District health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in the District of Columbia is contained in *Handbook Release 152*, dated June 17, 1968, of the Social Services Administration. The policy states that social workers will "inform mothers and other persons in the home of child-bearing age of family planning services offered by the Department of Public Health." In addition to this basic policy document of the Social Services Administration, the Commissioner (Mayor) on September 21, 1971 issued *Administrative Instructions* on the "Provision of Birth Control Information and Other Services." This policy states that "birth control information, services and devices shall be provided by the health facilities operated by the District of Columbia" and these services "may be provided by any qualified person or institution without regard to the age or marital status of the patient or the consent of the patient's parent or guardian." *Handbook Release 152* contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the 1968 policy, the Department of Social Services authorizes the referral of eligible public assistance recipients to family planning clinics operated by the Department of Public Health. *Handbook Release 152* states that "The Department of Public Welfare will make available to the Department of Public Health a listing of families who are receiving AFDC [Aid to Families with Dependent Children] for comparison with the Health Department's record of persons who are participating in the family planning program." The Social Services Administration, however, does not itself purchase family planning services for eligible public assistance recipients.² There is no single, standard, District-wide reimbursement rate for medical family planning procedures. The Social Services Administration has no contracts with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance are eligible for family planning

medical services. Applicants, past recipients, and potential recipients of such assistance, and residents of low-income areas are eligible for referral services.

There are no additional limitations that affect the provision of services to adults or minors, and the above noted *Administrative Instructions* specifically state that family planning services may be provided to minors without the consent of parents or guardians.

4. *Administration*:⁴ The responsibility for family planning services is assigned to the Bureau of Social Services and Resources. The Bureau has one full-time Family Planning Consultant. The Bureau's family planning activities include the training of local staff and the organization of regular periodic group sessions on sex education for pre-adolescent and adolescent male and female wards of the agency.

5. *Financing*:⁵ The Social Services Administration received no specific appropriation for family planning services in fiscal year 1971.

6. *Voluntary Sterilization*: The Social Services Administration has no written policy on voluntary sterilization, but the CFPPD survey indicated that the Administration *authorizes referral* for sterilization procedures.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the District welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the D.C. Medicaid program, family planning services are "Provided. No limitations. . . . Basis of reimbursement variable according to provider utilized." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid, see Federal Laws and Policies Section of this report.)
3. As reported in CFPPD survey, unless otherwise indicated.
4. Ibid.
5. Ibid.

American Samoa

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* American Samoa has no law establishing a family planning program.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

However, we are informed by the Attorney General that contraceptives are available through prescription only and are not available to minors. The Attorney General also states that the family planning clinic in American Samoa's only hospital limits its family planning services to married persons "because of the Samoan customs." Letter of Donald C. Williams (by Tala A. Tulafono) to Harriet F. Pilpel, Oct. 20, 1971.

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. Letter from Attor-

ney General Donald C. Williams (by Tala A. Tulafono) to Harriet F. Pilpel, Oct. 20, 1971. We are informed by the Attorney General that contraceptives are not available to minors. *Ibid.*

B. Laws Relating to Voluntary Sterilization

We have found no statutes or cases regarding voluntary sterilization in American Samoa. We are advised by the Attorney General that the family planning clinic in American Samoa's only hospital performs voluntary sterilization on married persons if both spouses consent. Letter from Attorney General Donald C. Williams to Harriet F. Pilpel, Oct. 20, 1971.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

No information is available.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

American Samoa has no welfare program.

Guam

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Guam has no law establishing a family planning program.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* While it is a misdemeanor under Guam's Penal Code to write or publish any notice or advertisement of any medicine or means for the prevention of conception, Guam Pen. Code § 317 (1970), we have been informed by the Attorney General that, to his knowledge, "this section has never been used in any prosecution nor is there any indication that it will be so used at the present time." Letter of Vincent T. Perez to Paula G. A. Ryan, Nov. 19, 1971.

4. *Laws Relating to Contraceptive Services to Minors:* Minors are all persons under 21 except married females over 18. Guam Civ. Code § 25.

Males between 18 and 21 and females between 16 and 18 may marry with parental consent. Females over 18 do not need parental consent. Letter from Attorney General Vincent T. Perez to Harriet F. Pilpel, October 14, 1971.

"In general the Guam Memorial Hospital and the Department of Public Health require consent to be given for medical treatment of any type. In view of this, it has been the policy of both the hospital and the department of Public Health to require an adult's consent, usually the parent or guardian of the minor, for services provided to the minor child. In the absence of a parent or guardian or other interested adult, the hospital will request the Attorney General to obtain a court order permitting or ordering the hospital to provide the necessary treatment. The court may order a temporary guardian for the sole purpose of consenting to hospital treatment, the court may order the child's hospitalization pursuant to Chapter III of Title XLVII relating to the mentally ill or the court may provide treatment under the juvenile court code relating to children who are wards of the court or in the custody of the juvenile home. The latter order is given under Section 265 of the Juvenile Code which is in the Code

of Civil Procedure." Letter from Attorney General Vincent T. Perez to Harriet F. Pilpel, October 14, 1971.

"Guam has no specific laws regarding the availability to minors of contraceptive drugs and appliances and family planning services." *Ibid.*

"The laws relating to the treatment of minors for venereal disease or pregnancy are no different than those pertaining to the adult with the exception of Section 9530.20, Government Code of Guam which requires that parents, guardians or other persons having the care of minors shall not conceal the fact of a minor child having any communicable disease including venereal disease. There are no laws specifying the method or type of services or treatment given to minors nor any restrictions on the same." *Ibid.*

B. Laws Relating to Voluntary Sterilization

We have found no statutes or cases regarding voluntary sterilization in Guam. We are advised by the Attorney General that "Guam has no laws specifically relating to voluntary sterilization although the Guam Memorial Hospital does maintain its own policies in that regard." Letter from Attorney General Vincent T. Perez to Harriet F. Pilpel, Oct. 14, 1971.

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current health agency policy on family planning consists of a statement regarding the family planning program of the Maternal and Child Health Services of the Department of Public Health for the Government of Guam. The policy covers counseling and assistance in fertility control and infertility correction, eligibility for family planning services, content of family planning medical services, patient referrals, and record keeping. With respect to follow-up responsibilities, the statement says, "patients are personally responsible for following the doctor's recommendations." The statement presents a recommended topic for use in counseling parents. The policy consists of five pages of double-space type, unpaginated, and undated.

2. *Eligibility:* Medical family planning services are available to "all parents and would-be parents," ac-

according to the policy statement cited above. "Family Planning Services shall be available to anyone who is living in Guam. . . . All services and supplies shall be given free . . . to patients, in conformity with current practices in other programs. . . ." Income is not apparently an eligibility criterion for family planning services.

3. *Administration*: No information available.

4. *Financing*: \$5,481 of new MCH funds were allocated to Guam for FY 1971 which were federally earmarked for family planning and \$152,683 of non-earmarked MCH funds were allocated.¹ No informa-

tion is available as to expenditures of these funds or of other funds.

5. *Voluntary Sterilization*: No information available.

Footnote:

1. Figures on allocations of MCH formula grant funds to the Department of Public Health are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

No information is available.

Puerto Rico

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:* Puerto Rico's Eugenics statute, P.R. Laws Ann. tit. 24, §§ 201 to 204 (1964), authorized the Secretary of Health to regulate the "teaching and divulgation of eugenic principles in public health units and prenatal, maternological, pueri-cultural centers, and public maternity clinics or hospitals" and to issue licenses to teach and practice eugenic principles in public health institutions and centers to certain categories of physicians and midwife-nurses.

Married persons and persons who, though not married, "publicly live in concubinage" may receive contraceptive information and services in the following cases: 1) infection in parent(s) may lead to aborted fetus or birth of abnormal child; 2) parents' "organic poverty or physiological wretchedness" may lead to abortion, fetal death, or birth of congenitally weak offspring; 3) mental abnormality of parents; 4) drug addiction of parent(s); 5) venereal infection of parent(s); 6) danger to health of mother; 7) parent's habitual criminality; 8) poverty of parents.

Note that this statute does not prohibit private physicians or clinics from furnishing family planning services to persons who are not married or living together.

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* The Eugenics statute discussed above is the only statute regulating the sale or distribution of contraceptive drugs or appliances.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* Puerto Rican law prohibits advertising or posting in public a notice or advertisement giving information on prophylactics and articles or means of preventing conception. P.R. Laws Ann. tit. 10, § 315 (1964).

4. *Laws Relating to Contraceptive Services to Minors:* The age of majority is 21. P.R. Laws Ann. tit. 31, § 971 (1968).

We have no relevant information as to whether Puerto Rican courts follow the general pattern of permitting medical treatment for minors without parental consent in emergencies and where the minors are "emancipated" or whether Puerto Rican courts would accept the "mature minor doctrine"

described in the Summary and Analysis of State Laws relating to Contraceptive Services to Minors. However, the categories of persons to which contraceptives may be disbursed may include minors.

B. Laws Relating to Voluntary Sterilization

Voluntary sterilization is legal and widely used in Puerto Rico as a method of birth control. See Back, Hill & Stycos, *Population Control in Puerto Rico: The Formal and Informal Framework*, 25 *Law & Contemp. Prob.* 558, 571 et seq. (Summer, 1960); Presser, *The Role of Sterilization in Controlling Puerto Rican Fertility*, XXIII *Population Studies* 343 (November, 1969).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* Official policy on family planning for the Commonwealth of Puerto Rico is contained in the following documents: *Population and Family Planning Report*, Governor's Advisory Council, November 1969; Governor's Annual State of the Commonwealth speech, January 1970; *Proposal for Island-wide Family Planning Program*, Department of Health, April 1970; *Continuation Application, Family Planning Project No. 758*, Department of Health, April 1971.

The latter two items are detailed proposals for federal funding of a comprehensive island-wide family planning program. The proposals contain detailed descriptions of family planning needs in Puerto Rico, existing services, objectives of the program, organization of the family planning program, a plan for program development and implementation, and evaluation procedures. The continuation application presents data on first-year operations and a discussion of program organization.

2. *Eligibility:* There are no eligibility requirements or patient fees for family planning services established or recommended in official Department of Health policy. Apart from official policy, the Department of Health reported in the CFPPD survey that all categories of minors are eligible for services in the program, except that minors who are unmarried, not emancipated, or not previously pregnant, must have parental consent. No minimum age requirements for services to minors are specified.

3. *Administration:*¹ The Maternal and Child Health Division has administrative responsibility for family

planning services in the Commonwealth Department of Health. Staff assigned to family planning services in the Department include: one project coordinator, 10-25 percent time; one project director, full-time; one assistant project director, full-time; one project administrator, full-time; and one project demographer, full-time.

The Department performs the following functions in support of family planning activities: consultation; training; development and distribution of public educational materials; central data processing; and purchase or provision of supplies, equipment or other materials to local family planning programs. The Department is responsible for "implementing, operating and supervising the family planning services at the local level," including the hiring of all clinic personnel and the provision of all supplies.

4. *Financing*:² \$255,992 of new MCH funds were allocated to Puerto Rico for FY 1971 which were federally earmarked for family planning; the total allocation to the Commonwealth of nonearmarked MCH funds for FY 1971 was \$1,390,237. No estimate of expenditures for family planning from these allocations is available. The Department of Health received a \$496,280 appropriation for family planning from the Commonwealth's legislature in FY 1971. No other funds were spent by the Department for family planning services.

5. *Voluntary Sterilization*: The Department has no written policy in regard to voluntary sterilization.

Footnotes:

1. Information contained in this section was reported by the Commonwealth health agency in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the state health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Although the Puerto Rico Department of Social Services apparently has a written policy on family planning, there is no available information on its title, provisions or date.

2. *Referral and Purchase Provisions*:¹ Under the policy, as reported in the CFPPD survey, the Department of Social Services recommends that local welfare agencies refer eligible public assistance recipients to medical family planning services. The Department of Social Services, however, does not itself purchase family planning services for eligible public assistance recipients. Although the policy is not clear on this point, it would appear that the Department of Health and other public medical resources are expected to provide the necessary medical services.²

The Department of Social Services reported that it has contracts and/or other formal arrangements with providers of services for the provision of family planning services.

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as applicants, past recipients, and potential recipients of such assistance, General Assistance recipients, and residents of low-income areas are eligible for referral to medical family planning services. There are no additional limitations that affect the provision of services to adults. Parental consent is required for the provision of services to all minors except those that are married.

4. *Administration*:⁴ Administrative responsibility for the welfare family planning program apparently is not assigned to any particular subdivision or unit in the Department of Social Services. Family planning activities of the Department, however, include the training of local welfare staff, the development and distribution of public educational materials, and other activities connected with referral and follow-up services. The following personnel are assigned full-time to family planning: one director of family planning; one demographer; one marriage counselor; one social service technician.

In addition, 40 Social Service technicians and four nurses are assigned full-time to referral, counseling and outreach activities.

5. *Financing*:⁵ There is a specific Commonwealth appropriation for family planning activities in the Puerto Rico Department of Social Services. In the Commonwealth's last fiscal year, which ended June 30, 1971, there was an appropriation of \$500,000 to the Department of Social Services for family planning. These funds are apparently being used to support the administrative costs of the Department's central staff and its 52-member field and support staff which provides training, referral and follow-up services.

6. *Voluntary Sterilization*: The Department of Social Services does not, apparently, have a written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the Commonwealth welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971 states that under the Puerto Rico Medicaid program, family planning services are "Provided. Limited to services provided by pharmacies and salaried personnel of publicly operated medical facilities. ... Included in operational costs of facilities which are financed through appropriated funds." The extent of utilization of the Medicaid program for family planning services is unknown. (For additional information on Medicaid see Federal Laws and Policies section of this report.)
3. As reported in CFPPD survey, unless otherwise noted.
4. Ibid.
5. Ibid.

Virgin Islands

A. Laws Relating to Contraception

1. *Laws Establishing Family Planning Programs:*

The Virgin Islands has no law establishing a family planning program. There is general authorization for the Department of Health to participate in preventive medicine programs and cooperate with federal grant-in-aid programs. V.I. Code tit. 3, § 418 (1957).

2. *Laws and Court Decisions Relating to Sale and Distribution of Contraceptives:* None found.

3. *Laws and Court Decisions Relating to Dissemination of Information, Advertising and Display Respecting Contraceptives:* None found.

4. *Laws Relating to Contraceptive Services to Minors:*

The age of majority is 21. V.I. Code tit. 16, § 261 (1957). There is a judicial procedure available for the emancipation of certain minors. V.I. Code tit. 16 §§ 231–254 (1957).

We are informed by the Department of Law that “there are no provisions of law relating to [family planning] services to minors, but as a policy matter such services are made available subject to parental consent.” Letter from Peter J. O’Dea, Special Assistant for Legislative Affairs, to Harriet F. Pilpel, Oct. 20, 1971.

The Virgin Islands Code provides that “[p]ersons who suffer from venereal disease are entitled, without regard to whether they can afford to pay for their medical treatment, to demand that they be taken under treatment at public expense, and likewise are under obligation to submit themselves to such treatment . . .” V.I. Code tit. 19, § 33(1957). In the opinion of the Deputy Assistant Attorney General, “because of the detrimental and communicable nature of venereal disease, a minor could demand treatment at public expense and further has the moral obligation to submit himself to treatment for the said disease, without parental consent.” Letter from Deputy Assistant Attorney General Ive A. Swan to Mrs. Carmen Lake, November 24, 1971.

B. Laws Relating to Voluntary Sterilization

No information was obtainable with regard to the law relating to voluntary sterilization in the Virgin Islands. However, the Department of Health both refers and pays for voluntary sterilization of both men and women who wish it; the women, however,

must meet an age-parity formula (see Health Policy, Sterilization, below).

C. Health Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Health Policy:* The current written policy on family planning of the Department of Health consists of a *Family Planning Manual* dated September 1970. The *Manual* sets forth objectives of the family planning program:

A. To provide women freedom of choice to determine the number and spacing of their children, through family planning services. . . .

B. To materially improve the health of women by providing prophylactic and screening physical exams and laboratory services

C. To reduce fetal mortality by preventing criminal abortion due to unwanted pregnancies

D. To strengthen the integrity of family life

E. To encourage community participation in family planning programs in the clinics, hospitals and homes

Policies discussed in the *Manual* cover eligibility, freedom from coercion, standards for family planning services, eligibility for sterilization services, the organization of the Family Planning Council in the Virgin Islands, methods of birth control (including sterilization), patient instruction for various methods, and family planning clinic routines.

2. *Eligibility:* The *Manual* states that “family planning services and information will be provided to all females who are desirous of limiting their families. . . . Family planning services will be given to all women regardless of race, creed, color or income Minor females will be given family planning services only after a signed consent is obtained from parent or legal guardian. . . . Family planning education will be offered to all interested males” The Department of Health indicated in the CFPPD survey that married and emancipated minors do not require parental consent. The Department neither recommends nor establishes geographical eligibility requirements or patient fees.

3. *Administration:*¹ Administrative responsibility for family planning services is not assigned to a specific unit of the Department of Health. The following full-time health agency staff are assigned to family planning services: Four obstetricians, eight nurse-midwives and three health aides. Two social

aides are assigned to family planning 10–25 percent time.

The Department performs the following functions in support of family planning activities: consultation; development and distribution of public educational materials; and purchase or provision of supplies, equipment or other materials to local family planning programs.

4. *Financing*:² \$3,267 of new MCH funds were allocated to the Department of Health in FY 1971 which were federally earmarked for family planning; the total allocation to the Virgin Islands of non-earmarked MCH funds for FY 1971 was \$153,735. No estimate is available of MCH expenditures for family planning from these allocations; \$116,412 was appropriated by the legislature in FY 1972 family planning programs. Local health department funds totalling \$16,860 were spent for family planning services in the following categories: transportation, \$2,000; recruitment of staff, \$3,000; purchase of laboratory equipment, \$375; purchase of drugs and biologicals, \$500; printing, \$800; appliances, \$1,000; contraceptive supplies, \$2,125; textbooks, \$200; educational leaflets, \$400; educational equipment, \$2,500; and clinics, \$3,960.

5. *Voluntary Sterilization*: According to the *Family Planning Manual*, cited above, the Department of Health's policy on voluntary sterilization for males and females is as follows: "Ladies desiring sterilization (tubal ligation) will be referred to the GYN clinic at the hospital. They will be interviewed and examined by the family planning clinic obstetrician and a note of consultation and recommendation for the procedure will be given to the patient. Women will be eligible for tubal ligation if the sum of their parity times their age equals 120. . . . Males desirous of sterilization will be referred to the surgical clinic for this procedure." According to the Department, this policy is intended to encompass both *referral* to and *purchase* of sterilization services for men and women.

Footnotes:

1. Information contained in this section was reported by the Department of Health in the CFPPD survey.
2. Figures on allocations of MCH formula grant funds to the health agency are from Director's Letter MCH-71-1 (Maternal and Child Health Service, DHEW), January 22, 1971.

D. Welfare Department Policies Relating to Family Planning and Voluntary Sterilization

1. *Summary of Current Welfare Policy*: Welfare family planning policy in the Virgin Islands is contained in a one-page statement, dated July 1970, which outlines the role of the Insular Department of Social Welfare under "a cooperative agreement with the Department of Health and several other

community agencies in making available" family planning services. The statement provides that the welfare family planning contribution will include social services, baby-sitting services, the provision of volunteer subprofessional workers for family planning clinics, the provision of space for "possible evening clinics," and the Department will also: "explore the possibility of providing part-time social workers to assist at the family planning clinic." The policy contains no statement on the objectives of the family planning program.

2. *Referral and Purchase Provisions*:¹ Under the policy, the Department of Social Welfare *requires* local welfare agencies to *refer* eligible public assistance recipients to medical family planning services. The Department reported: "All Medical Services for Family Planning are financed by a special Family Planning Project Grant" of \$125,000 from the DHEW National Center for Family Planning Services to the Department of Health.² The cooperative agreement described above is apparently funded by this grant which, according to the Department, receives 75 percent federal funds and 25 percent local matching funds.

3. *Eligibility*:³ All current recipients of federally-aided assistance as well as applicants, past recipients and potential recipients of such assistance, General Assistance recipients, and residents of low-income neighborhoods are eligible for medical family planning services.

There are no additional limitations that affect the provision of services to adults. Parental consent is required for all minors except those that are married or emancipated.

4. *Administration*:⁴ The Division of Child and Family Services in the Insular Department of Social Welfare has administrative responsibility for the welfare family planning program. Two Health Aides are assigned full-time to family planning. The Director of Child and Family Services and the Executive Assistant to the Commissioner spend less than 10 percent of their time on family planning. Family planning activities include the training of local welfare staff, the development and distribution of public educational materials, and the provision of subprofessional workers to assist the family planning clinics.

5. *Financing*:⁵ There is a specific legislative appropriation for family planning activities in the Insular Department of Social Welfare. During the Islands' last fiscal year, which ended June 30, 1971, there was an appropriation of approximately \$13,000 to the Department for family planning services.

6. *Voluntary Sterilization*: The Department of Social Welfare has no written policy on voluntary sterilization.

Footnotes:

1. Unless otherwise indicated, information in this section was reported by the welfare agency in the CFPPD survey.
2. DHEW, Medical Services Administration, *Public Assistance Series No. 49*, 1971, states that under the Virgin Islands Medicaid program, family planning services are "Provided. Including drugs, supplies and devices, when under supervision of a physician. Physicians' services limited to those provided in a Health Department facility or by professional staff of the Health Department. Drugs,

supplies and devices limited to those provided by the pharmacy of a Health Department facility or by a private practicing pharmacist having an agreement with the Health Department... Basis of reimbursement variable according to provider utilized." The extent of utilization of the Medicaid program for family planning service is unknown. For additional information on Medicaid, see Federal Laws and Policies section of this report.

3. As reported in CFPPD survey, unless otherwise indicated.
4. Ibid.
5. Ibid.



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